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UNIVERSITY OF ALBERTA

ADOLESCENT SUBSTANCE ABUSERS' PERCEPTIONS OF FAMILY FUNCTIONING

BY

TERESA COWAN

A thesis submitted to the faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION.

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

FALL 1994

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The undersigned certify that they have, read and recommend to the Faculty of Graduate Studies and research for acceptance, a thesis entitled Adolescent Substance Abusers' Perceptions of Family Functioning submitted by Teresa Cowan in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

Don Sawatzky

Henry L. Janzen

Janis Blakey

Date: Sept 27/1994

To my furry friends

Abstract

A family systems approach was used to investigate the family functioning of adolescent substance abusers. Family functioning was defined in terms of cohesion and adaptability measured by Olson's Family Adaptability and Cohesion Scale (FACES II, 1982). The perceptions of forty-two substance abusing adolescents clients from two substance and alcohol day clinics were compared to the norming sample established by Olson (1982). The CAGE questionnaire was used to measure the extent of the adolsecent's substance problem. The acronym "CAGE" is formed from the four questions which make up the CAGE measure (see Appendix A). The drinking habits of the adolescents' parents were examined in order to further divide the substance abusers into Children of Alcoholic's (COA) and non-COA groups.

The results indicated that the substance abusing adolescents perceived their family system relationships as rigid and themselves as disengaged within the family. The COA substance abusers perceived their family systems as being even more rigid than the non-COA substance abusers. The COA substance abusers also obtained higher CAGE scores indicating a more debilitating relationship to substance use than the non-COA substance users. There were no differences between the male and female subjects, and no differences for the type of substance used by the adolescents. A significant percentage of adolescents in this study had parents who were either abstainers or heavy drinkers.

"T" tests were used to evaluate statistically the major hypotheses in the study. Partial correlation coefficients, t-tests, Chi-square, and one

way analysis of variance were computed to examine the effects of age, gender, CAGE scores, type of substance used, parents drinking habits and the family function variables, and to answer related research questions.

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CHAPTER ONE: INTRODUCTION

The present study employed a family systems approach to examine the family context of adolescent substance abuse. More specifically, the study explored the relationship between adolescent substance abuse and present family functioning as perceived by the adolescent.

Statement of the Problem

The objective of this study is to examine the family dynamics associated with adolescent substance abuse. Using the Circumplex Model of Family Functioning (Olson, 1982), the dynamics of the substance abusers' families will be examined in terms of cohesion and adaptability imbalances. The families of the adolescent substance abusers will be further explored with regard to parental alcohol abuse in terms of the following question; how are the families of adolescent substance abusers whose parents abuse alcohol, different than adolescent substance abusers whose parents do not abuse alcohol?

Substance use has become a cultural norm for the North American adolescent (Kovach & Glickman, 1986; Lawson & Lawson, 1989). By the age of eighteen 90% of adolescents have used licit or illicit drugs or a combination of both (Felsted, 1986). While some adolescents have become substance abusers, the majority of youth have used drugs without crossing the line toward substance abuse or dependency. What factors lead the experimenting adolescent or social substance user into a lifestyle of substance abuse?

Within the past thirty years, the research into individual psychopathology as a symptom of family dysfunction has grown,

especially from the perspective of Family Systems Theory. Researchers, theorists and practitioners from this orientation have attempted to describe how an individual's psychopathology can be related to the interaction and structural variables of one's own family (Kerr & Bowen, 1988; Minuchin, 1974; Watzlawick, Beavin, & Jackson, 1963).

For the adolescent, the family context as the hub of individual pathology takes on even greater significance for several reasons. Firstly, as a child within a family system, the family becomes the intermediary between the individual and society. That is, it is the family which prepares the individual to function in society (Schuster & Ashburn, 1980). Secondly, unlike earlier or later developmental tasks, the passage through adolescence requires significant adaptations on both the part of the adolescent and the parents (Carter & McGoldrick, 1989). For the adolescent this requires a successful negotiation of the separation and individuation stage. The parents fulfill their role in this process by offering support to their child, while simultaneously learning to let go. Family members, at this time, will experience different levels of stress which have been generated from this stage (Santrock, 1987; Schuster & Ashburn, 1980). Often the developmental task of adolescence brings forth family, family-of-origin, and marital conflicts requiring even more adaptations and understanding on the parent's part (Carter & McGoldrick, 1989).

Adolescence is a time when even the healthiest families may have difficulty finding new ways to cope. However, research indicates that healthy or balanced families tend to pass through times of stress with few repercussions for the marital dyad, family group, or individual, while dysfunctional or imbalanced families may develop individual or family problems (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1983).

Substance abuse is just one of the ways in which family dysfunction can manifest; delinquency, eating disorders, family violence or divorce are others (Levine,1985).

Research into the families of substance and non-substance abusers suggests that families have the capacity to either buffer against substance abuse or maintain and contribute towards it (Bennett, Wolin & Reiss, 1988; Brook & Brook, 1987; Kovack & Glickman, 1986; Needle, Lavee, Sus, Brown, & Doherty, 1988). It is the purpose of this study to examine some of the family variables connected with youth substance abuse.

Rationale

In the literature, various chemical dependencies are dynamically indistinguishable from each other. Alcoholism, drug abuse, substance abuse, addiction, and many other terms are used to describe the behavior involved in a person's destructive relationship with a chemical (Edwards, 1990; Lawson & Lawson, 1989; Levine, 1985; Straussner, 1993). In addition, the personal, familial and societal factors which contribute to the substance abuse are more similar for all types of substance than they are different (Kaufman, 1985).

Adolescent substance abuse poses a serious problem to the adolescent, the immediate family and to society. At the society level, the impact of substance abuse has far reaching effects with its connection to crime, suicide, automobile accidents and fatalities (Straussner, 1993). Although alcoholism and drug abuse are both associated with similar personal, familial and societal factors, the statistics available primarily relate to alcohol abuse.

Alcohol related highway death is the number one killer of the 15 to 24 year old group. The teenage driver is responsible for 44% of all fatal crashes at night where alcohol is involved (Lawson & Lawson, 1989). Over 10,000 young people aged 15 to 24 are killed each year in alcohol related accidents in the United States (Coombs, 1988).

In addition to the personal and familial devastation that drug related accidents, crime and suicide can cause, substance abuse affects the user on both psychological and social levels. Substance abuse has a debilitating effect on the psychological processes and tasks the adolescent must achieve in order to pass successfully into adulthood. Because substances substitute chemically induced feelings for natural ones, they act as a social and emotional barrier, shielding youth from normal problem solving experiences and impairing judgment, discrimination and information processing abilities. The substance induced dysfunction of developmental and social tasks can severely disrupt interpersonal relationships at home and elsewhere (Coombs, 1988; Levine, 1985).

> Adolescent drug abuse may be leading a whole generation of handicapped young people unable to function effectively in an increasingly demanding world. We must help to preserve our most valuable resource - our youth. (Reidinger, 1980 p.7)

Adolescence as a family life cycle event, can become a significant factor in the etiology of teen substance abuse. It is therefore important to assess the substance abuse within the context of the family.

> The life cycle model is clinically relevant to an understanding of alcohol problems because the family's developmental stage and the individual's developmental stage intersect to become a context in

> which an alcohol problem may become both a cause and effect of dysfunction. Drinking both disrupts accomplishment of developmental tasks and may be a response to stresses imposed by specific developmental phases. (Krestan & Bepko, 1989 p. 483)

A gap in the literature suggests that substance abusing adolescents have not been explored in terms of their family history of alcohol abuse. Children from alcoholic families are referred to as "children of alcoholics" or COA's. Examining adolescent substance abusers in terms of their COA status is important for several reasons. Firstly, in a review of the literature, the more recent contributions suggest that substance abusers from alcoholic family backgrounds have been exposed to a unique set of family dynamics (Brown, 1988; Galanter, 1991; Robinson, 1989). Secondly, in addition to the regular abuse and dependency issues, counsellors and therapists have found that substance abusers from alcoholic family backgrounds have a unique set of needs in relation to the family's alcoholism. They contend, that if therapy is to be successful, the substance abuser's family dynamics (which has organized itself around the family-of-origin alcoholism) needs to be addressed (Brown, 1988; Felsted, 1986). It is for these reasons that the present study has broken down the substance abusing adolescents into COA and non-COA groups.

This study is concerned with assessing the adolescent substance abuser's perceptions of the self-in-relation to the family system. An assumption of this study is that the perceptions of substance abusers reflect their phenomenal reality and determine the nature of their responses and interactions between themselves and family members. Cognitive psychologists have shown how our thoughts, actions and feelings result from our perceptions of events and not from the actual

events themselves (Ellis, McInerney, DiGiuseppe, & Yeager, 1988; Matlin, 1983). Young substance abusers are viewed as symptomatic of family dysfunction. Behaviors occur as a specific response to their perception of particular interaction patterns within the family system.

The FACES II instrument, which is based on the Circumplex Model, will be used to examine the adolescents' perceptions of family functioning. The FACES II has been designed to be administered twice to provide two types of scores. The first score asks how the adolescent currently views the family; this is called the "real" score. The second application asks how the adolescent would like to see the family; this is called the "ideal" score. The differences between the real and ideal scores are typically used to assess the level of family satisfaction, that is, how content the child is with their view of the family. However, for the purposes of this study, the ideal scores will be examined in terms of the levels of family functioning.

In a review of the literature, substance abusing adolescents were assessed on a similar concept of real and ideal scores for family functioning using the Kvebaek Family Sculpture Technique (KFST) (West, Hosie, & Zarski, 1987). The authors of this study examined 35 adolescents hospitalized for substance abuse. They found that while the adolescents' real scores fell in the dysfunctional or imbalanced range, the ideal scores also fell in an imbalanced range. However, the ideal scores fell in the opposite direction of the real scores. For example, when real scores indicated emotionally isolated family relationships, the ideal scores for the subjects would be enmeshment. The authors (p. 486) further explain,

because the KFST is experimental, findings should be compared with data generated from other instruments in the field of family therapy. For example, the Cohesion Scale from the Adaptability and Cohesion Scales (FACES II).

By using the FACES II to examine the ideal scores in terms of family functioning, the results of the KFST may be explored and possibly validated.

The results of this study will be of interest to counsellors and family therapists working with substance abusing adolescents. The results may aid to increase the understanding of the relationship between substance abusing adolescents perceptions of family functioning and their parents drinking habits. By examining the substance abuser's ideal scores for dysfunctional levels of family functioning, one may determine whether educational interventions to inform individuals how optimal families operate are required. It is hoped that the information gained from this study will contribute to the research knowledge of family dynamics and teen substance abuse.

Research Questions

The defined problem of this study is the investigation of family systems imbalances in relation to substance abuse in adolescence. The study focused on the following objectives:

1. to determine significant differences in the levels of family functioning in substance abusing adolescents as compared to the norm group;
2. to identify particular family system configurations that serve to maintain and are maintained by the substance abusing adolescent;

3. to determine significant differences in the levels of family functioning in the COA substance abusing group as compared to the non-COA substance abusing group;
4. to assess differences of substance abusers' real and ideal scores in terms of the ideal scores falling in an opposite direction to the real scores.

Definition of Terms

While the majority of adolescents are using alcohol and other psychoactive substances, not all of them experience a problem due to such use. It is therefore helpful to conceptualize alcohol and other drug use as ranging on a continuum from non-problematic experimental and social use, to pathological abuse, dependence or addiction.

The APA 1994 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines "abuse" as the continued use of psychoactive substances despite the experiencing of social, occupational, psychological, or physical problems; recurrent use in situations where the use is physically hazardous, such as driving while intoxicated; and a minimal duration of disturbance of at least one month. The DSM-IV further differentiates "psychoactive substance abuse" from "substance dependence" which it defines as the existence of at least three of nine symptoms (see Appendix B). Substance dependence, which may vary in severity from mild to severe, refers to compulsive use of a chemical and continued use despite adverse consequences. It further implies a tolerance to the substances and the individual can not wait too long

between doses without experiencing a craving and dependence on the substance.

For the purpose of this study, the CAGE questionnaire was used to assess the severity of the drug and alcohol problem, although it is understood that all subjects in the study entered the counselling and treatment programs due to a substance problem. The word "CAGE" is an acronym formed from the four questions which make up the measure (see Appendix A). A low CAGE score indicates substance abuse and a high score suggests substance dependence (Ewing, 1984). The term substance or drug abuse will be used through out the study in place of substance dependence. The author assumes a substance problem exists for the participating adolescents but further assessment would be necessary before one may label these adolescents as substance dependent.

As discussed earlier, drug and alcohol abuse connotes a similar pathological background such that research with one type of substance abuse can be applied to another type of substance abuse. While there are occasional differences, these are usually of degree instead of type (Kaufman, 1985).

Throughout the literature in the mental health fields, the term "dysfunctional" is frequently used to describe families, individuals, relationships, or systems. The term "dysfunctional" implies a negative emotional, shame-based label. Families and individuals who struggle with drug or personal problems have been annoyed and discouraged to be told they are dysfunctional (Fields, 1992).

Where appropriate, the word dysfunctional will be replaced with "imbalanced". Family systems theory often uses as an image an out-of-

balance mobile to describe a family having difficulties. This is accepted as a far more positive approach for individuals attempting to understand themselves or their family.

Children of Alcoholics or COAs refers to those individuals who grew up with one or both parents having a drinking problem or alcoholism. The drinking habits of the parents will be described using three categories; heavy drinkers, moderate drinkers and abstainers. The heavy drinking parent is synonymous with alcohol abuse or alcoholism, which in turn produces the COA. The term children of alcoholic (COA) will be used interchangeably with the terms heavy drinkers, and a family history positive of alcohol abuse (FHP). The non-COA status will encompass those subjects who have moderate drinking parents and those parents that are abstinent.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

Research and clinical data reveal no single cause for alcohol abuse and addiction (Fields, 1992; Straussner, 1993). While many indepedent factors have been posed, a multifactoral perspective views alcoholism as an interplay between variables (Pattison & Kaufman, 1982). This approach suggests that alcohol abuse and dependence results from a combination of biochemical, genetic, familial, environmental and cultural factors, as well as personality dynamics. Research into adolescent substance abuse using a multivariate design to consider a variety of factors, indicates the family plays a pivotal role in the ability to either buffer against the adolescent alcohol abuse or to maintain and contribute towards it (Bennett, Wolin & Reiss, 1988; Brook & Brook, 1987; Kovack & Glickman, 1986; Needle, Lavee, Sus, Brown, & Doherty, 1988). While many variables are seen to influence adolescent substance abuse, it is the main assumption of this study, that family dynamics play a major role in the adolescent's substance abuse.

This chapter attempts to link family systems theory and family systems research to substance abuse in adolescents. In order to provide the reader with a comprehensive understanding of the family context, a brief explanation of adolescence and the family life cycle will be reviewed.

Adolescence and the Family Life Cycle

Adolescence

Adolescence is a psychosocial stage of development that links childhood to adulthood. The tasks of adolescence prepare the individual for adulthood. The adolescents' main accomplishment during this time is to establish themselves as individuals separate from their parents; this developmental task is called "separation-individuation" (Schuster & Ashburn, 1980). Individuation during adolescence is defined as a sharpened sense of one's distinctness from others and a heightened awareness of one's self-boundaries (Santrock, 1987). It is critical for adolescents to gain difference and distance from their parents during this time, if the stage is to be successfully negotiated.

Another task that parallels the separation-individuation process is "identity development". As adolescents begin to differentiate themselves from others, they develop a sense of who they are. According to Erickson (1968), adolescents will try out different roles and personalities in their quest for an identity. As young people come to an understanding of how they are different from others and as they discover which personality roles most suit them, they will gradually begin to solidify a social identity. For Erickson, the central ingredient of this task is the establishment of a clear path toward a vocation or an occupational or social role that society can identify them by.

While attempting to establish self-identity, adolescents will often pursue images and personal styles that frequently challenge the values and beliefs of their families. For example, wearing heavy-metal rock-

group T-shirts, piercing noses or "hanging" with the "biker" crowd may lead to conflicts with parents, often times developing into struggles over rules, roles, and relationships. Carter and McGoldrick (1989) suggest that adolescents act so obnoxiously to make it easier for parents to let them go, or alternately, that parents become difficult as a means to make it easier for adolescents to let go. Either way, some adolescents and their families will experience considerable stress, while others will have relatively few intense problems. The parents' own psychological development can influence the outcome of stressful events. For example, parents with a strong sense of self can be less reactive to their adolescent's challenges. Parents who feel personally attacked when criticized by their adolescent will tend to defend themselves during times of conflict. Those parents who remain objective and feel secure with themselves when under attack are more able to negotiate differences (Carter & McGoldrick, 1989).

Adolescence is also a period of development when the individual pushes for autonomy. Autonomy refers to the ability to behave independently, to do things on one's own. It implies that one has control over making decisions about one's life. For the successful outcome of this stage, the parents need to provide a supportive and nurturing home base while allowing the adolescent more personal control through the use of democratic parenting (Pardeck & Pardeck, 1990). This is not an easy task for parents who may be experiencing criticism from their children, and who are witnessing vastly different values and ideals than their own.

It may be evident by now that both the adolescent and his or her parents have the ability to affect the outcome of the developmental stages. The parents, as the architects of the family, can set up an

environment that will contribute towards either a successful or a negative outcome of the tasks at hand (Minuchin, 1974). A strong, yet flexible family that is able to support growth provides an ideal setting in which the adolescent can master developmental tasks (Carter & McGoldrick, 1989).

It has been suggested that adolescents are more likely to achieve autonomy or individuation in families where they are encouraged to participate in decision-making. The authoritarian parenting style which values obedience and believes in restricting the child's autonomy can result in dependence or antisocial activities (Pardeck & Pardeck, 1990).

For adolescents whose parental support is lacking, the task of separation becomes more difficult. Adolescence is a time of loss for all families. Parents often feel a void as adolescents move toward greater independence because they are no longer needed in the same way and the nature of caretaking needs changes. For families that have experienced earlier losses or rejections, the process of letting go becomes intensified. Separation for these families is seen as dangerous, and strenuous efforts by the parents are often made to prevent the child from separating (Carter & McGoldrick, 1989).

While some families are afraid to let the adolescent go, others seem to push their child from the nest. Premature separation can result when parents are either overwhelmed by the tasks of adolescence and let outside authorities take control (ie. social services), or they themselves have been abused and neglected and therefore tend to abuse and reject when they lose control or feel helpless. Parents who are emotionally disturbed or are substance abusers may have adolescents who are forced into premature autonomy (Carter & McGoldrick, 1989).

Research involving the developmental tasks of identity development and separation indicates that adolescents who lack support and acceptance from home will usually place more importance on their peer group (Coombs, 1988). If the peer group is using drugs and the adolescent has a weak bond or relationship with the parents, the youngster will more than likely become involved with drugs (Brook & Brook, 1987; Needle et al., 1988). The adolescent will often seek a career or identity within the drug subculture when other avenues have failed him (Coombs, 1988). Children who have repeated a grade are eight times more likely to become substance abusers (Kovack & Glickman, 1986). Substance abuse is also associated with boredom in class, dissatisfaction with school subjects and conflict with teachers (Kovack & Glickman, 1986). Adolescents who are having difficulty at school in terms of their academic and personal life will typically have problems identifying with the student role. The drug-user identity, however, offers the failing adolescent a more obtainable and rewarding role. These adolescents find support and acceptance within the drug culture, something that they lacked at both school and at home.

The Family Life Cycle

The family, like the individual, moves through a more or less predictable life cycle. The assumptions of this view maintain that there is a strong interdependence between family members. Family members must change the rules for interrelating along each stage of the family's development, and the stage of adolescence can precipitate the most profound shifts of all.

> Adolescence demands structural shifts and renegotiation of roles in families involving at least three generations of relatives. Adolescent demands for more autonomy and independence tend to precipitate shifts in relationships across generations... Because adolescent demands are so strong, they often serve as catalysts for reactivating emotional issues and they set triangles in motion. The struggle to meet these demands often brings to the surface unresolved conflicts between parents and grandparents, or between the parents themselves. (Carter & McGoldrick, 1989, p 256)

In addition to the re-organization of the parent-child relationship during adolescence, the parents often experience a "mid-life crisis" during this period. The parents positive resolution of their mid-life identity crisis appears positively related to the level of emotional autonomy reported by the children (Silverberg & Stienberg,1987). It appears that both middle-aged parents and their adolescent children may be involved in developmental changes that affect their interactions with each other and the outcomes of each other's stage.

In summary, how a family is able to either buffer against substance abuse or contribute towards it depends on how both the adolescent and the parents handle the stress and adaptations that are necessary for this stage. In addition, adolescence and the family life cycle are interrelated with the family system. Based on family systems theory, the manner in which a family system functions or is organized and structured, will greatly affect the outcome of the adolescence stage and consequential substance abuse.

Theory and Research of Substance Abusing Families

Family Systems and Substance abuse

Systems Theory has emerged as one of the leading theories within the fields of psychiatry, psychology, and social work for explaining substance abuse and dependency (Pardeck, 1991). In Systems Theory there is a shift in focus from the individual to the family unit as both the source of the problem, and the solution to it (Kaufman, 1981). The behavior of every individual is seen as related to and dependent upon the behavior of all other family members (Minuchin, 1974). With the family systems concept, the family functions as an emotional unit, with each member playing a role in how the rest of the family feels, thinks, and acts (Kerr & Bowen, 1988).

Substance abuse by any family member is viewed as a family problem not an individual one (Bepko, 1985; Bowen, 1991). A family systems approach suggests that young people who abuse substances are often significantly connected to their family of origin. Their behavior is tightly bound up with family pressures resulting from adolescence itself and the young person's push toward separation and individuation. Substance abuse within this context usually functions to retard or postpone the process of separation and can preserve the imbalanced alignments of the troubled family system (Levine, 1985).

Structurally, families of adolescent substance users manifest intergenerational coalitions with the adolescent usually enmeshed with the opposite sex parent (Levine, 1985; Stanton & Todd, 1982). According to Kerr and Bowen (1988), this structural dynamic is called

"triangulation", and when the family holds to it inflexibly, pathology in the triangulated daughter or son emerges. Early research in the form of case studies, focused on the symbiotic tie between drug addicted sons and their mothers. This relationship was further accompanied by the lack of involvement with their fathers (Levine, 1985).

In systems theory, the child's substance abuse is viewed in terms of a homeostatic mechanism. The substance abuse serves as a stabilizing function whenever the family begins to get out of balance (Kaufman, 1986; Stanton & Todd, 1982; Steinglass, 1979). For the triangulated family system, the adolescent's substance abuse would seem to pull an overly distant father back into the family in order to deal with a crisis related to the adolescent. The parents would then begin to fight over how to best deal with their problem child. While on the surface the arguing appears negative, it is in fact serving to draw a distant marital unit together.

While much of the earlier research on substance abuse and families has focused on the heroin addict and case study triangles (Kaufman, 1981; Stanton, Todd, Heard, Kirschner, Kleinman, Mowatt, Riley, Scott, & VanDeusen, 1978), recent literature has focused on abuse of the softer drugs such as alcohol and marijuana (Brook & Brook, 1987; Glynn, 1984, Smart and Chibucos, 1990). In addition, the more recent work has explored the interactional characteristics which differentiates the families of substance abusers from non-substance abusers. Generally, however, both perspectives appear to support each other in their findings.

Parent-Child Relationship

While the current research into substance abuse and the family is vast, many of the findings can be placed under particular headings. By far, the most significant correlates with adolescent substance abuse involve the parent-child relationship. The quality of the parent-child relationships may be one of the most important factors in predicting whether drug use will become a problem for certain adolescents . In this instance, the "quality" of the parent-child relationship refers to the following attributes; a loving relationship, openness, mutual respect, and democratic parenting (Brook & Brook, 1987; Glynn, 1984).

Research indicates that families of substance users are emotionally isolated (Coombs, 1988; Searight, Manley, Binder, Krohn, Rogers, & Russo, 1991). There is also a substantial amount of research suggesting that substance abusing adolescents have an absent or uninvolved father (Glynn, 1984; Stoker & Swadi, 1990). The drug-user parent-child relationship has further been described as unemotional, distant and critical, with a perceived absence of !ove and acceptance. (McKay, Murphy, Rivinus,& Maisto, 1991; Needle et al., 1988).

Conversely, Coombs and Landsverk (1988), found that a positive parent-child relationship deterred adolescent substance abuse. Other researchers have reported similar results. Fathers and mothers who develop and maintain warm relationships with their children experience the greatest success in inhibiting drug involvement (Kandel, 1982; Stanton & Todd, 1982). In a longitudinal study, Brook and Brook (1987) found evidence that an affectionate and non-conflictual parent-child relationship, in which children identify with their parents, insulates both

preadolescents and adolescents from greater involvement in alcohol use over time.

Adolescents experiencing emotional isolation will have a more difficult time separating from the family than children who experience warm and involved relationships. Bowlby (1980), in a discussion of attachment theory, maintains that children unable to form a close and nurturing relationship with a parent will experience significant difficulties forming a positive identity, and will experience considerable difficulty in separating. The adolescent without emotional support is caught up in an approach-avoidance situation. On one hand they seek the independence that adolescence offers, however, a lack of emotional support makes them fearful of stepping out into the world. In essence, they do not have the psychological strength or maturity necessary for this task (Santrock,1987). The substance use offers them a feeling of independence from the family in the form of rebellion, while simultaneously debilitating their personal lives such that a dependence on the family still occurs (Levine, 1985).

Stanton and Todd (1978) have coined the term "pseudoindividuation" to refer to the solution the adolescent reaches when successful separation can not be achieved. The substance abuse behavior permits the addict to simultaneously be both close and distant, "in" and "out', competent and incompetent, relative to his or her family of origin. The adolescent can maintain family ties, while simultaneously appearing defiant and independent. Stanton and Todd explain how the majority of drug addicts are involved in a triangular relationship with their father and mother, where the father-child relationship is characterized as being emotionally isolated, and the mother-child relationship is enmeshed. The

authors believe the triangular relationships help the addict maintain ties to the family (although debilitating) for many years. Although research suggests there are ties to the family and enmeshment occurs, this does not always imply that affectionate bonds are present (Coombs, 1988).

In a study by Friedman, Utada, and Morrissey (1987), ninety six adolescent substance abusers and their families were assessed using a self-report measure and a family therapy assessment. While the families were assessed as having enmeshed relationships, the family members themselves had a marked tendency to rate themselves as disengaged from the system. Friedman and associates (1987) explained that the discrepancy between the adolescent's self-rating score and the therapist's assessment may be due to the nature of enmeshed relationships. While triangular relationships were present indicating enmeshment, the lack of a warm and caring family environment was perceived by the respondents. In general, a negative emotional undertone appeared to characterize the substance abusing families (Glynn, 1984; Greenblatt & Schuckit, 1976; Kaufman, 1981, 1986).

Communication in the families of substance abusing adolescents is most often characterized as conflictual and distant (Kovack and Glickman, 1986; Pardeck, 1991). Kirschenbaum, Leonoff and Maliano (1974) describe communication in these families as excessively intellectual, or rational, with no intimate feelings being shared. Reilly (1976) found a similar theme in that communication was primarily negative, affectless and without intimacy.

Stoker and Swadi (1990) using a non-clinical group of 300 adolescents found two completely contrasting views of family relationships involving drug users and non-users. While non-users

tended to perceive their families as warm and caring, drug users saw their families as distant and insulated with frequent parental disagreement and conflict. Users reported that they had difficulty communicating with both parents and they perceived them as mistrusting, verbally punitive and critical. The fathers, on the whole, were ineffective and generally absent as a significant figure, while most of the communication came from the mothers, although this was usually in a negative context.

Kaufman (1981) observed families with substance abusing members. He found the interactions of these families to be dull, lifeless, and joyless, except when mobilized to deal with the child's substance abuse. It is interesting to note how Kaufman's description of marital communication frequently takes place with reference to the teens drug problem. This observation reinforces the concept of a triangular relationship between parents and substance abusing child. In this example, the adolescent's substance abuse preserves the family balance by serving as a center of communication. The family is held together and energy is generated into the system by the focus on the teens substance problem.

For the substance abusing teen, there appears to be little family conversation, and what conversation there is, usually takes place within a conflictual context. According to Kerr and Bowen (1988), inherent in intergenerational coalitions is a troubled marital dyad. Stanton and associates (1978) found a predominance of disturbed marital relationships in substance abusing families. Similar studies have correlated family conflict and adolescent substance abuse (ie. Needle et al., 1988; Pardeck, 1991). Although conflict is characteristic of adolescent substance abuser's families, there is disagreement about its correlation with divorce. Some studies found adolescent substance

abuse more prevalent in divorced families (Jurich, Polson, Jurich & Bates, 1985), while other studies indicate that little, if any correlation exists (Fawzy, Coombs, Simons & Bowman-Terell, 1987). It appears that the increase in substance abuse and divorce is more related to parenting. Divorced parents tend to be either more laissez-faire or authoritarian with their children, both of which have been associated with higher rates of substance abuse (Coombs & Landsverk, 1988).

Parenting Skills

Parenting during adolescence can be a challenging time for many. In a large scale study of families across the life-cycle, researchers Olson, McCubbin, Barnes, Larsen, Muxen, and Wilson (Cit op. Noller & Callan, 1986) found that family stress was higher during adolescence than at any other stage in the life-cycle. Also, adolescent issues were the single largest cause of stress in families. It is therefore easy to understand how marital and family satisfaction are at their lowest levels during this stage. While adolescence may prove to be a difficult time for some parents, families who have an alcohol or drug abusing adolescent experience even higher levels of stress (Kovack & Glickman, 1986).

Styles of parenting and their effects on adolescent substance use have been examined for some time. Parental styles that are authoritarian and laissez-faire are common in families with substance abuse problems (Lawson & Lawson, 1989) and these parenting styles are consistent with negative communication patterns that are characteristic of adolescent substance abusers' families (Coombs, 1988). Both parenting styles indicate a lack of communication and involvement on the parent's part. In the laissez-faire style of parenting, the child sets his or her own limits and

there is little parental involvement. The authoritarian parent determines all the rules and limitations for the child, and again, there is little input or communication between the parent and child.

Laissez-faire parenting and over permissiveness have been related to greater alcohol use (Brook & Brook, 1988). Similar findings maintain that the parents of more frequent substance users are characterized by their lack of of limit setting (Levine & Kozak, 1979). At the other end of the parenting scale, authoritarian parenting has also been associated with substance abuse (Jurich, Polson, Jurich & Bates, 1985). The authoritarian style which often includes corporal punishment can result in antisocial activities. The autocratic approach attempts to exert a high degree of control over the child, and is associated with lower levels of adolescent autonomy and independence (Pardeck & Pardeck, 1990).

Closely related to parenting skills is parental modeling. Though this type of influence is a more passive component in the family interaction, it is no less powerful an influence. Adolescents are more likely to drink and use other drugs if their parents do. Kandel (1982) found that 82% of drinking families raise youth who also drink, while 72% of abstaining families produce abstainers. Fawzy, Coombs and Gerber (1983), produced similar findings. The researchers found that parents who take one or more drinks of beer or wine per day are more likely to have offspring who use substances (ie. fathers 72%; mothers 77%). It was also found that parental substance use produced a generalizing affect in their children. That is to say, the children approximated parental behavior and used a variety of substances than their parents did. However the researchers in this study did not differentiate between abusers and users in their sample. Again, it is important to note that substance use by

adolescents is the cultural norm (although substance abuse is regarded as pathological).

While the previous research indicates that adolescents are more likely to drink and smoke if their parents do (and they will generalize to other drugs), the following studies examined the relationship between parental and adolescent substance abuse.

> Children with alcoholic parents have more problems with alcohol than children who come from nonalcoholic homes. This statement has been supported by virtually every family study of alcoholism. (Lawson & Lawson, 1989, p. 235)

For children who have alcoholic parents; 30% are alcoholic, 40% are moderate drinkers, and 30% are abstainers. For children whose parents drink moderately; 5% are alcoholics, 85% are moderate drinkers, and 10% are abstainers. For children whose parents are abstainers; 10% are alcoholics, 50% are moderate drinkers, and 40% abstainers (Lawson, Petereson & Lawson, 1983). In 1984, Holland and Griffin examined patterns of adolescent substance use and found 61% of the substance using adolescents came from families with drinking problems.

In a recent large scale study of 8000 Greek high school students (grades 9 and 12), adolescents with an alcoholic parent reported regular alcohol use three times more frequently than the rest of the sample (Hyphantis, Koutras, Liakos & Marselos, 1991). Similar findings linking parent's heavy use of drugs and alcohol to their adolescents substance abuse have been found (Fawzy et al., 1983).

Research overwhelmingly indicates that parental substance abuse correlates strongly with the adolescent abuse, however, the foundational theories behind this differ. Though heredity alone has not been shown to

cause alcoholism, it can be a significant contributing factor (Goodwin, 1984). Alternately, the familiy dynamics created by the alcoholism, accounts for a great deal of the risk that children of alcoholics experience (Bowen, 1991; Brown, 1986). Due to the vast amount of information on the nature of the alcoholic family environment and Alcoholic Family Systems, this topic will be discussed forthwith.

Loss and Death

Themes and events of loss and death have been found to be a important correlate of substance abusing families. The literature points to higher frequencies of parental and sibling death in the families of substance abusers (Coleman, Kaplan & Downings, 1986; Stanton & Todd, 1978). Coleman et al (1986) for example, found that families of youthful substance abusers had experienced significantly more deaths than samples of families of psychiatric outpatients and normal students. Similar studies comparing adolescent substance abusers and non-abusers found a higher incidence of death in the family (Stoker & Swadi, 1990).

Researchers have found a connection between death and family life-cycle disruptions (Carter & McGoldrick, 1989). The degree of disruption or problems the family experiences because of death can be affected by several factors. The timing of the death in the life-cycle of the family, the openness or ability of the family to emotionally share their grief, and the position in the family the deceased member held. Walsh (1993), for example, found that two significant life cycle events occurring closely together in time (such as the death and birth of two members), is

correlated with symptom development at a much later time in the life-cycle, such as during the adolescent leaving home stage.

Brown (1989) suggests that the adjustment of a child to the death of a parent largely depends upon how that parent handles his or her grief. Parents who withhold emotional expression and are unable to share in their child's grief process produce adjustment problems for both the parent and child. Compas and associates (1986) found that a supportive relationship was a significant factor in preventing psychological problems after a family crisis. These findings would suggest that death does not lead directly to substance use, but rather that, it is the quality of the family relationships which buffer against life stressing events.

Alcoholic Family Systems

The Centrality of Alcoholism

From a family systems approach, alcoholism is viewed as a family disease (Bowen, 1991; Steinglass, 1979). Exploring imbalanced family structures and interactions has replaced the disease model of alcoholism which views pathology as resting within the individual (Galanter, 1991). Brown (1988) described the alcoholism of a parent as a central organizing principle determining interactional patterns within the family.

> The family is dominated by the presence of alcoholism and its denial. The alcoholism becomes a major family secret, most often denied inside the family and certainly denied outside. This secret becomes the organizing principle around which the family organizes - its adaptations, coping strategies, and shared beliefs that maintain the structure and hold the family members together. (Brown, 1988, p. 27).

Alcohol use becomes a problem when the individual ceases to choose alcohol freely and begins to need it (Brown, 1988). A dysfunctional family system is set in motion when the alcoholic must invoke the defenses of denial and rationalization in order to maintain a belief that he is still in control.

Role structure becomes one of the basic changes that occurs in an alcoholic family. For example, if the alcoholic member is the father, he may neglect his responsibilities at times. The performance of these duties will then have to be taken up by other members of the family, possibly the children. Denial serves to cover up the irresponsibility of the alcoholic member and leads family members to believe that this is how a normal family operates (Brown, 1988). In fact, denial is one of the strongest reasons why families fall into a pattern of roles which maintain the alcoholic behavior (Felsted, 1986). There is little flexibility in an alcoholic family. The roles for non-alcoholic family members are limited and rigid, with the alcoholic defining what roles are available and what rules apply (Barnard, 1990).

In summary, research indicates that alcoholic families are characterized by more family conflict (Kaufman, 1986), rigidity (Preli, Protinsky, & Cross, 1990), triangular relationships (Bowen, 1991) and emotional isolation (Preli, Protinsky, & Cross, 1990) than non alcoholic family systems.

Children of Alcoholics

As a result of the family's need to create defenses against alcoholism, problems related to childhood developmental stages and tasks occur (Kaufman, 1986). In 1969, Cork coined the term "Children of Alcoholics

(COA). The COA had been recognized as a type of childhood trauma with resulting problems and dysfunction of its own (Brown, 1988).

Denial is the most common means alcoholic families use to cope and survive their pain. As a part of their attempt to smooth over family problems, co-dependents pretend everything is okay. To accomplish this the child's reality is invalidated; "Dad's not an alcoholic, he just drinks to relax", or "it's your fault Dad drinks... if you did your chores better he would not be so mad and have to use a drink to calm him down." Children in alcoholic families learn to distrust their own observations and feelings; "Don't talk, don't feel, and don't trust" are the rules of the family system.

Straussner (1993) refers to the narcissistic injury the COA suffers. While the normal parent-child attachment is characterized by the parent valuing the child, the alcoholic parent may value his or her drugs more than the child. As the alcoholic's needs take precedence over the child's needs, a false sense of self develops in the child. Instead of the natural egocentrism or focus on the self that characterizes an important developmental stage of children, COA's spend their time reacting to the alcoholic, and anticipating their needs.

Being an adolescent COA creates many problems for the accomplishment of developmental tasks. For the COA, the task of identity formation and separation-individuation will be affected by the faulty attachment bond. When the parent's needs take precedence over the child's needs, a loss of self, rather than an autonomous self, develops. The COA has difficulty even distinguishing what his or her own needs and feelings are (Littrell, 1991). The inner voice which calls most adolescents

to separate, is muffled by the noise and needs of the alcoholic family system.

However, alcohol abuse can help the adolescent COA with separation and identity formation. Alcohol offers the COA the ability to identify with roles, personalities and emotions normally closed off to them. Alcohol use makes being irresponsible easier for the over-responsible child. It allows the COA to get directly in touch with his or her anger, something they may have sublimated to maintain the family balance. The alcohol also allows the normally fearful and untrusting adolescent to feel more comfortable with intimate relationships (Felsted, 1986).

Even the adolescent COA's who have bonded satisfactorily with a parent figure have a hard time separating. They find it difficult to leave behind other siblings who may need help. Alcohol abuse for these adolescents helps to dull the pain and their rebelliousness makes it easier to leave home. Worse yet, the adolescent may identity with the alcoholic family member and become alcoholic themselves.

The COA is more likely to become alcoholic than the child who does not have a family history of alcohol abuse. As explored earlier, the COA adolescent has a 30% chance of becoming an alcoholic. The family dynamics created by the alcoholism prevent role flexibility. Alcoholic families have limited responses and roles available to them. They are characterized as being extremely rigid with the children experiencing a deep sense of emotional isolation (Kaufman, 1986).

The research on alcoholic families and the families of adolescent substance abusers indicates that they have similar family characteristics such as higher rates of family conflict, triangulation and emotional isolation. However, the centrality of alcohol in the alcoholic family system

creates a fundamental difference in family structure and dynamics. How this difference relates to the COA adolescent substance abuser and the non-COA substance abusers perception of family functioning will be investigated in this study.

The Circumplex Model of Family Functioning

The primary aim of this study is to examine the relationship between family functioning and adolescent substance abuse. Family systems theory was the paradigm of choice principally because of the "family context" and its theoretical shift to circular causality; where both the adolescent and the parent are seen to influence each other in the developmental tasks and problems each encounters.

Olson's Circumplex Model (1979) is an empirical approach that attempts an integration of family systems concepts and empirical studies in the marital and family literature. It was designed "to provide a framework that could be used by clinicians working with families to make a more systemic diagnosis and to establish more specific treatment goals" (p. 20). The model explicitly examines the dynamics of the family system and will be used in this study to assess family functioning as perceived by the adolescent substance abuser.

The Circumplex Model combines two structural dimensions, adaptability and cohesion (see Figure 1). Each dimension has four levels creating a sixteen category typology of family systems. The instrument used to measure these dimensions is called the Family Adaptability and Cohesion Scale or FACES for short (see Appendix C).

Family adaptability has to do with the extent to which the family system is flexible and able to change. Family adaptability is defined as

"The ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and

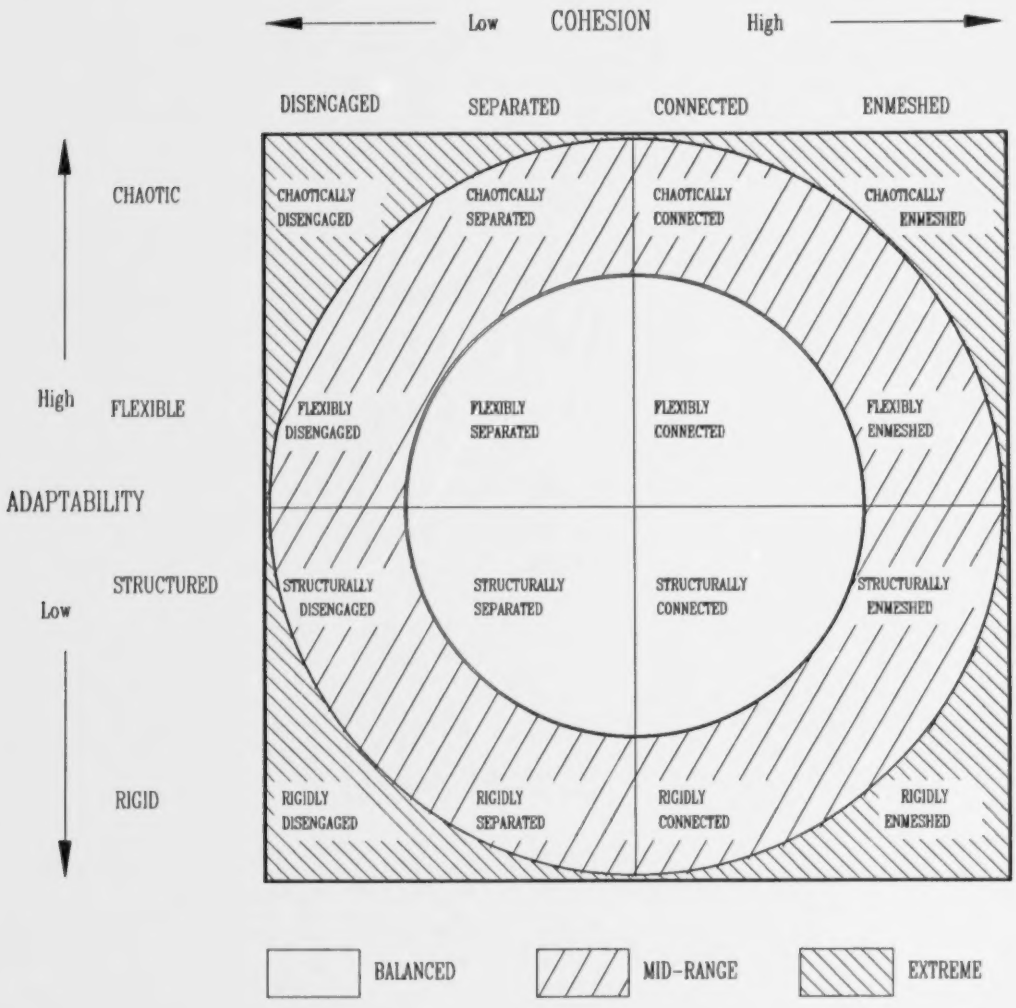


FIGURE 1: THE CIRCUMPLEX FAMILY MODEL
(Olson, 1982)

developmental stress" (Olson, 1979, p.20). Within the Circumplex Model, specific concepts used to diagnose and measure the adaptability

dimension are: family power (assertiveness, control, discipline), negotiation style, role relationships and relationship rules.

Family cohesion assesses the degree to which family members are separated from or connected to their family. Family cohesion is defined as "the emotional bonding that family members have toward one another" (Olson, 1993 p.105). Specific concepts used to diagnose the cohesion dimension are: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests and recreation.

The major theme in Olson's (1979) model is balance. Extreme levels of either adaptability or cohesion are potentially detrimental to family functioning and to the well-being of individual family members. On the other hand, families in the balanced area of the model are more able to handle change and react to normal transitions in the family, while also providing a necessary degree of emotional bonding and support. Essentially, balanced families are a dynamic open system, which allows for change and growth within and outside the family unit. Also, balanced families tend to have very good communication. For example, families in the balanced range of adaptability can share roles, and negotiations are open and actively include children (notice how both of these activities require good communication). "Extreme" family systems on the other hand, tend to have poor communication as can be seen in the one-way communication process that describes authoritarian parenting, typically is associated with the rigid "extreme" family system (Olson, 1993).

Reviews of studies employing the Circumplex model indicate how symptomatic families tend to fall into the extreme ranges, while non-symptomatic families are more balanced (Olson, 1993). For example, 66% of sex offender's family-of-origin are found in the extreme range,

while only 11% of non-offender control families fall into the extreme. Also, 59% of delinquent adolescent families fall within the extremes, while 19% of normal adolescent's families fall within this range.

Substance abusing adolescents and the families of substance abusers have also been located within the "extreme" ranges of the Circumplex Model. Using the FACES II, researchers Smart, Chibucos, and Didier (1990), in a three year cohort study of adolescents, found that extreme family functioning is related to greater risk of substance abuse among adolescents than is either balanced or midrange functioning. Preli and associates (1990) studied all family members in substance abusing families and they discovered that substance abusing families tend to fall within the extreme ranges when compared with control families.

For the adolescent substance abuser, research indicates that family relationships are characterized as emotionally isolated, distant and lack a warm and caring parent-child relationship (Friedman et al., 1987; McKay et al., 1991; Searight et al., 1991; Stoker et al., 1990; West, et al., 1987). The FACES II describes these relationships as "disengaged" on the cohesion scale. A disengaged relationship falls within the extreme range and exemplifies extreme emotional separateness. Individuals come and go in these families with a lack of interest on each other's part and members are unable to turn to one another for support (Olson, 1993).

Problems during adolescence have been related to inflexible family systems. Adolescence has been described as an intense period of developmental stress to which the family must respond and adapt. While a balanced or healthy family responds to change through flexibility in their negotiation of the family power structure, roles and rules (Carter & McGoldrick, 1989; Olson et al., 1979), the substance abusing family

typically responds to change in a more rigid manner (Lawson et al., 1983; Levine, 1985). With a rigid family structure, the family continues to respond to stress with minimal change to the roles and rules in the family.

While alcohol and substance abusing families have typically been associated with rigid family structures, there have been reports where chaotic family functioning has occurred (Preli et al., 1990). In a chaotic family there may appear to be no rules and no one in particular appears to be running the family (Olson, 1979). In general, adolescence ushers in a time in which all family members must adapt to changing circumstances. Too much change in response to situational and developmental stress leads to chaotic family systems, while too little change leads to rigid systems. Alcohol abuse has been associated with both of these systems, although more so with the latter.

Summary

Emerging from the literature there is a strong relationship between adolescent substance abuse, family dynamics and the adolescence stage of the family life cycle.

Adolescence is a time when parents need to create more space in their relationship with their child, while also providing enough emotional support. A key for success during this stage is flexibility (Carter & McGoldrick, 1989). However, the research indicates that adolescent substance abusers come from more inflexible families. Additionally, adolescents who experience isolation or distant parent-child relationships are more susceptible to substance abuse.

In Family Systems, the nature of circular causality allows for behavior to be both a cause and effect. For example, the adolescent distances

her/himself because the family rejects her/him, or the family maintains a distance because the child is too far away to reach. Either way, the substance abuse serves to maintain the family's homeostasis by creating a conflict or triangular relationship around which the family organizes their relationships. In addition, the substance abuse provides a sense of distance or separation from the family for the adolescent (this is referred to as pseudoindividuation). The substance abusers withdrawal from the family looks and feels like separation and individuation, however, the debilitating affects of drugs serve to keep the adolescent tied into the family system.

While both COA and non-COA substance abuser families have similarities, research indicates the children from homes with an alcohol or drug abusing parent experience an unusual family dynamic and should be considered as a special population. The families roles and rules are derived from the alcoholism and the central nature of alcohol in the family system. These families are characterized by extremes, in terms of their rigid nature, triangular relationships, conflicts and isolation.

Hypotheses

Healthy or optimal family functioning has been referred to by Olson (1979, 1982, 1993) as a balance between change and stability in the family (adaptability), and between togetherness and separateness (cohesion). Based on the Circumplex Model, family systems theory and research on adolescent substance abuse can be referred to in terms of family imbalances. Research on the adolescent substance abuser suggests the family of the adolescent substance abuser is imbalanced on both the adaptability and cohesion dimensions. Working within this

framework some questions for exploring the adolescent substance abusers perceptions of family functioning will be postulated. These questions formulated as hypotheses are as follows:

HO I: Adolescent substance abusers as compared to the adolescent norm group characteristically perceive themselves as disengaged within the family system.

HO II: Adolescent substance abusers as compared to the adolescent norm group characteristically perceive the relationships within their family system as being more rigid.

HO III: Substance abusing adolescents who are COA or have a family-history-positive of alcohol abuse will significantly perceive the family system as even more extreme and rigid than the non-COA substance abusing adolescent.

HO IV: Substance abusing adolescents whose real scores fall into the extreme range will have ideal scores falling into the extreme and polar opposite range to their real scores.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

The objective of this study was to investigate family system imbalances in terms of family functioning in relation to substance abuse in adolescents. Chapter two summarized some of the research regarding families of adolescent substance abusers. Highlights of the research suggested inflexible families and families in which the adolescent feels emotionally isolated, are strong correlates for substance abuse. The FACES II is the instrument of measurement that will be used in the study. The FACES II is able to assess both the level of family flexibility and cohesion or sense of family togetherness.

Sample

Research subjects consisted of adolescent clients from two drug and alcohol day treatment programs in the Vancouver Lower Mainland. The clinic provides counselling services and activities for the substance abusing adolescents and their families. The adolescents were referred to the programs by school counsellors, family members, social services, and self-referral.

The sample consisted of 46 subjects, however four responses were spoiled reducing n=42. There were 21 male and 21 female subjects, whose ages ranged from 14 to 19 years, with the average age 16. 5 years (SD = 1.5 years). The average age for the female subjects was 16.3 years and the average age for the male subjects was 16.8 years. When examining the substances used by the adolescents, the following

breakdowns occurred: For the male subjects, 12 used drugs exclusive of alcohol, 6 used alcohol only, and 3 used a combination of both drugs and alcohol; for the female subjects, 11 used alcohol exclusively, 7 used only drugs, and 3 used a combination of drugs and alcohol. Out of the 42 subjects, 12 did not live at home, 7 of these were female, the remaining 5 were male. According to Blishen's (1976) socio-economic index for occupations in Canada, the subjects were from the lower-middle to middle social economic class.

Measures

Faces II

The Family Adaptability and Cohesion Scale II was used in the study. FACES II (1982) was designed to empirically test the concepts of family cohesion and family adaptability. Cohesion and adaptability are identified in the model as the primary dimensions of family functioning. *Cohesion* is defined as "the emotional bonding family members have with one another, and the degree of individual autonomy a person experiences in the family system" (Olson, 1993, p.105). *Adaptability* is defined as "the ability of a family system to change its power structure, codes, relationships and relationship rules in response to situational and developmental stress" (Olson, et al., 1979 p.20). The scale makes the assumption that families located within the balanced ranges of the scales are healthier than those at the extremes.

The instrument is composed of thirty statements on a five-point Likert scale. It should be noted that the questionnaire is designed to be administered twice; once for how family members perceive their family

currently (real score) and secondly, for how they would like the family to be (ideal score). By comparing the *real* and *ideal* score it is possible to assess the level of satisfaction within the family system for the individual. In addition, comparison of the real and ideal scores provides information regarding how the individual would like to see the family change and whether this change is in a positive direction or not.

Hampson, Hulgus and Beavers (1991) compared the Dallas Self-Report Family Inventory (SFI) with the FACES II. They found the following correlation's between the SFI global measure of family health and FACES II: for cohesion of 0.93, and for adaptability of 0.79.

A 30-item factor analysis as reported in the FACES II manual (Olson, 1982), indicates eight content areas which load on Factor I - Cohesion and six content areas which load on Factor II - Adaptability. The final 30-item scale contains 16 cohesion items and 14 adaptability items. There were two items for the following eight concepts related to the cohesion dimension: emotional bonding, family boundaries, coalition, time space, friends, decision-making and interests and recreation. There were two or three items for the six concepts related to the adaptability dimension: assertiveness, leadership, discipline, negotiations, roles and rules. The factor loadings for each item are given in the FACES II (Olson, 1982) manual.

Rodick, Henggeler and Hanson (1986) evaluated two of the basic assumptions of the Circumplex Model and the FACES instrument: (1) Healthy families evidence balanced degrees of cohesion and adaptability, whereas problem families evidence extreme degrees, and (2) families which fall in the balanced range have more positive communication skills than families in the extreme range. Using a matched sample, 29 juvenile

offenders and their mothers were compared to 29 adolescents with no history of arrest or psychiatric problems. Rodrick et al., (1986) found that more offenders fell in the extreme range and had poor communication skills than the non-offender families who fell in the balanced range. The researchers claim their findings supports the validity of the hypothesized relationship between cohesion and adaptability and family functioning. Similar research using families from clinical samples and comparing them to healthy families have produced similar findings as the Rodick et al., (1986) group (Needle, Lavee, Su, Brown, & Doherty, 1988; Smart, Chibucos & Didier 1990).

Reliability estimates (internal consistency type) for the FACES II norming samples varied as follows: cohesion .87, adaptability .78, with the total .90. The Pearson correlations on test-retest reliability estimates were .83 for cohesion and .80 for adaptability.

COA Item: The CAF

In order to identify the adolescent alcoholic as a COA, investigators have used a single item question (Galanter, 1991; Robinson, 1989). For eight years the Cambridge and Somerville Program for Alcoholism Rehabilitation (CASPAR) has used a single question survey form to identify COA's (Robinson, 1989). That item is known as the Children from Alcoholic Family (CAF) item:

> Have you ever wished that either one or both of your parents would drink less ?
>
> 1. Parents don't drink at all
> 2. Yes
> 3. No

DiCicco, Davis and Orentein (1984) found statistically that the CAF is reliable and valid as an identifier of COA's. Reportedly, there is considerable stability over time in the way teenagers answer the CAF item which suggests that their "wish" is a relatively enduring characteristic. Other data confirm that the CAF item coincides with clinical judgments. Among seventy-one respondents who said "yes" to the CAF item, for example, 83% were also identified by the clinical staff as COA's (Robinson, 1989). The nature of the single item measure helps to ensure cooperation on the part of the adolescent, who may become bored or restless with extensive questions and procedures.

Substance abuse and Dependency Item: The CAGE

The CAGE is a four item questionnaire designed to identify drug and alcohol problems. The word CAGE is an acronym based on words from each item, for example, the questions focus on **C**utting down, **A**nnoyance by criticism, **G**uilty feeling, and **E**ye-openers (See Appendix A). The CAGE has been reported to successfully distinguish alcoholics in hospital samples (Ewing, 1984). The CAGE consists of four items. Each item is answered positively (yes) or negatively (no). A positive response to two or more questions will classify an individual as an alcoholic (Ewing, 1984). While originally designed to assess alcohol abuse, the CAGE can also be used to assess abuse of other substances (Straussner, 1993). Where two positive responses on the CAGE is indicative of substance abuse, three to four positive responses indicates dependency. The CAGE according to Ewing (1984) is easier to use than the Michigan Alcoholism Screening Test (MAST) and is just as sensitive.

Procedure

Meetings were held at both drug and alcohol agencies in which the counselling staff were informed about the nature of the study. The counsellors recommended that they personally administer the questionnaires as the adolescents were anticipated to be less co-operative with an outsider. Written instructions designed for the counsellors to follow were explained to ensure that a standardization of test administration was achieved (see Appendix D).

Each questionnaire consisted of a packet with the parents consent and parts A, B, C, and D (see Appendix D). The parents consent provided information on the nature of the study, confidentiality and voluntary participation. Part A was a consent form for the adolescents to sign. It outlined the nature of the study, confidentiality, and that participation was voluntary. Part B was the FACES II for the real scores (to measure how the adolescent currently perceived their family). Part C was the FACES II for the ideal scores (to measure how the adolescent would like to see the family). Part D consisted of demographic questions, the CAF and CAGE items. The subjects completed the questionnaire during their weekly visit with the counsellor at the drug and alcohol treatment center. The subjects completed the questionnaire package in one sitting (which took about 30 minutes).

A debriefing session with the counsellors was held after all questionnaires had been collected and processed. Comments of the adolescents' reactions and the preliminary findings of the study were discussed.

CHAPTER FOUR: RESULTS

The present chapter will be presented in the following manner: each hypothesis will be restated to aid reader recall, then a description of the analysis performed to test the hypothesis will be discussed. Thereafter, with reference to the calculations performed and the tables of relevant data: conclusions will be drawn based on these findings.

As with all studies, certain related research questions or counter-explanations may be advanced. In order to answer these questions or to rule out counter-explanations for the findings, a series of additional calculations were performed. These additional calculations and the rationale for their inclusion, plus the implications of these results, are included after the main findings.

Hypotheses

HO I: Adolescent substance abusers as compared to the adolescent norm group characteristically perceive themselves as disengaged from the family system.

HO I Analysis

In order to test if adolescent substance abusers perceived themselves as more disengaged within the family system than the norm group of adolescents, a two tailed test of significance of the differences of the mean scores was performed. A "t" value of 11.64 was derived from the difference between means ($p<.0001$). Refer to Table 1.

TABLE 1: COHESION "t"-TEST

	n	Mean	Sd
Substance Abusers	42	38.62	11.07
Normal Group	416	56.30	9.20

"t" value = 11.64 p = 0.0000 p<.0001 Difference at 99.99% confidence

To better illustrate, the cohesion scores have been converted into percentages and collapsed into two groups, "disengaged" and "other" and presented in Table 2. It was noted that 83% of the substance abusing adolescents perceived themselves as disengaged within the family system as compared to 18% of the norm group.

TABLE 2: COHESION DISTRIBUTION

	Disengaged	Other
Substance Abusers	83%	17%
Normal Group	18%	82%

HO I Conclusion

A "t" value of 11.64 gives a p<.0001. The strong "p" value supports HO I, the adolescent substance abusers characteristically perceive themselves as disengaged within the family system.

HO II: Adolescent substance abusers as compared to the adolescent norm group characteristically perceive the relationships within the family systems as being more rigid.

HO II Analysis

To test if adolescent substance abusers perceived the family as more rigid than the norm group of adolescents, a two tailed test of significance of the differences of the mean scores was performed. A "t" value of 7.68 was derived from the difference between means ($p<.0001$). Refer to Table 3.

TABLE 3: ADAPTABILITY "t"-TEST

	n	Mean	Sd
Substance Abusers	42	35.50	8.55
Normal Group	416	45.40	7.90

"t" value = 7.68 p = 0.0000 p<.0001 Difference at 99.99% confidence

To better illustrate, the adaptability scores have been converted into percentages and collapsed into two groups, "rigid" and "other" and presented in Table 4. It was noted that 69% of the substance abusing adolescents perceived the family as a rigid family system, whereas only 15% of the norm group percevied their families as rigid.

TABLE 4: ADAPTABILITY DISTRIBUTION

	Rigid	Other
Substance Abusers	69%	31%
Normal Group	15%	85%

HO II Conclusion

A "t" value of 7.68 gives a p<.0001. The strong "p" value supports HO II, the adolescent substance abusers characteristically perceive the family system as rigid.

HO III: Substance abusing adolescents who are COA will perceive the family system as more rigid than the non-COA substance abusing adolescent.

HO III Analysis

The two sample t-test was used to compare the COA substance abuser with the non-COA substance abuser. A "t" value of 1.98 was obtained from the difference between the means (p<.054). Refer to Table 5.

TABLE 5: ADAPTABILITY (COA / NON-COA)

	n	Mean	Sd
Coa	14	31.93	7.10
Non-Coa	28	37.29	8.77

"t" value = 1.98 p = 0.0541 p<.10 Difference at 90% confidence

HO III Conclusion

The "t" value of 1.98 indicates a p<.054, thus HO III is confirmed. There is a marginal difference between COA substance abusers and non-COA substance abusers. COA substance abusers perceive their family

system as more extreme and more rigid than non-COA substance abusers.

HO IV: Substance abusing adolescents whose real scores fall into the extreme ranges will have ideal scores falling into the extreme and opposite ranges to their real scores.

HO IV Analysis

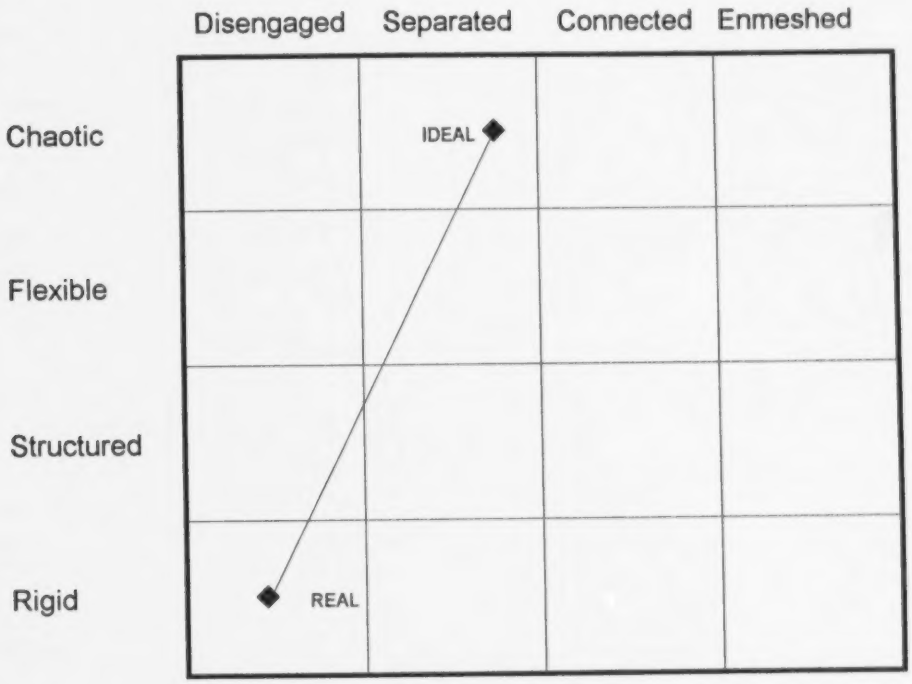
Inferential statistics were unnecessary to indicate a change here. A visual analysis was completed to see if the adolescent ideal scores fell into the extreme ranges. Refer to Table 6 which includes only the substance abusers with extreme scores on both the cohesion and adaptability dimensions. Note that 28 of the 42 subjects fell into the rigid and disengaged family type and represent extremes on both scales.

As can be discerned from Table 6, each dimension contains four levels. For adaptability, the real scores fell in the rigid category and rigid scores fall into the extreme range. The ideal scores for adaptability also fell into the extreme range by falling into the chaotic or very flexible category. The ideal scores for the cohesion dimension, however, did not fall into the opposite and extreme range. In fact, the disengaged cohesion score moved up only one level to the separated category.

HO IV Conclusion

Support for HO IV was partially met. The rigid extreme (real scores) fell into their opposite extreme (ideal scores) called very flexible or chaotic. The ideal scores, however, did not fall opposite to the real scores on the cohesion dimension. The ideal scores only moved up one level.

TABLE 6: DIFFERENCES BETWEEN REAL AND IDEAL SCORES



Commentary on Related Research Issues

A non-directional t-test was used to measure significance between the differences of the mean scores for the following groups: gender, parents drinking habits, CAGE, and type of substance abused.

For gender there was no significant differences on either the cohesion and adaptability for the real and ideal scores. The means for male and female were very similar as shown in table 7.

TABLE 7: GENDER "t"-TESTS

Female / Male	"t" value	p value	
Cohesion	0.19	0.85	p>.10 No difference
Adaptability	0.66	0.51	p>.10 No difference

The CAGE scores were assessed to look for differences between those scoring in the 1-2 range indicating substance abuse, and those in the 3-4 range indicating substance dependence. There was a marginal difference for both CAGE groupings indicating that CAGE scores in the 3-4 range had more extreme scores. Both of these scores show a difference at the 90% confidence level as shown in table 8.

TABLE 8: CAGE SCORES "t"-TESTS

Cage 1-2 / Cage 3-4	"t" value	p value	
Cohesion	1.85	0.07	p<.10 Diff at 90% confidence
Adaptability	1.86	0.07	p<.10 Diff at 90% confidence

The CAGE scores were also compared to the parents' drinking habits. Using the Chi-Square method in a 2 x 3 table, the adolescent's parent's drinking habits were explored in terms of heavy drinkers (COA group), moderate drinkers, or abstainers. The Chi-Square obtained = 5.13 with a p value = 0.07 indicating marginal differences, specifically, adolescents with higher CAGE scores (indicating dependency) had alcohol abusing parents.

The drinking habits of the parents of the adolescents were explored in terms of three groups; heavy drinkers (COA group), moderate drinkers,

and abstainers. One noteworthy finding indicated that the COA group showed more extreme scores for the adaptability dimension. This was explored in HO III.

The drug habits of the adolescents were studied using two groupings: alcohol only and other drugs. Where the alcohol group indicated only alcohol as the drug of use, the other drug group consisted of subjects who used a combinations of substances, one of which could be alcohol (ie. Marijuana and alcohol are used), analyses indicate virtually no difference between the groups as shown in table 9.

TABLE 9: DRUG TYPE "t"-TESTS

Alcohol / Drugs	"t" value	p value	
Cohesion	0.28	0.78	p>.10 No difference
Adaptability	1.38	0.18	p>.10 No difference

Age was examined in terms of five groupings; the 14-15 yr., 16 yr., 17 yr., 18 yr. and 19+ year olds. A one way ANOVA assessed the ages for differences on both the adaptability and cohesion scales. There were no differences for cohesion, (F-ratio = 0.96 with a p-value = 0.44), while the adaptability scale did show significance (F-ratio = 3.07, with a P-value = 0.03). The differences can be accounted for by the 17 and 19+ age groupings, both of which had significantly lower scores than the other groups as assessed by the t-test.

For the 17 year old group "t" value = 2.09 with a p value = 0.04 for adaptability and for the 19 year age group t-stat = 2.21 with a p value= 0.03 for adaptability. There was also a difference on the ideal scores (F-ratio = 2.83 with a p value = 0.04). Again, the 17 and 19+ year

old groups accounted for the differences here. The 17 and 19+ year old groups had higher scores for the mean ideal score.

For adolescent substance abusers who lived at home and those who resided outside the home, a t-test indicated that although there was a small numerical difference between these two groups there was no statistical difference (see table 10). For both groups, scores indicated a rigid and disengaged perception of family functioning, however, those adolescents residing outside the home had more extreme scores than the adolescents living in the home.

TABLE 10: RESIDENCE "t"-TESTS

Home / Away	"t" value	p value	
Cohesion	1.83	0.07	p<.10 Diff at 90% confidence
Adaptability	1.99	0.06	p<.10 Diff at 90% confidence

All the adolescent's scores on the cohesion scale were correlated with their scores on the adaptability scale. The correlation coefficient for the real scores r = 0.72, while the ideal scores r = 0.49. There was a moderately strong correlation between the cohesion and adaptability real scores, while 52% of the variance of the cohesion variable could be predicted from the adaptability variable.

Substance abuse and the Level of Family Functioning

According to Olson (1982), the amount of dysfunction or symptoms a family experiences can be related to their level of functioning. There are three levels of functioning in the Circumplex model; Balanced, Mid-range, and Extreme. Table 7 and Table 8 show the levels of family functioning

for the substance abusing adolescents and the norm group adolescents in this study. To determine the relationships between substance abuse and levels of family functioning, a Chi square value was computed.

TABLE 11: FAMILY FUNCTIONING CHI SQUARE TEST

	Abusers	Norm Group	Total
Extreme	26	79	105
Mid Range	11	143	154
Balanced	5	194	199
Total	42	416	458

Chi square = 41.99 p = 0.0000 p<.0001 Difference at 99.99% confidence

TABLE 12: FAMILY FUNCTIONING DISTRIBUTION

	Abusers	Norm Group
Extreme	62%	19%
Mid Range	26%	34%
Balanced	12%	47%
	100%	100%

The groupings in the Table 12 show the differences in perception of family functioning between the two groups, as marked by the negative skewness in the substance abusing group, (62% in the extreme, 26% mid-range and 12% balanced); and by positive skewness in the norm group, (19% extreme, 34% mid-range, 47% balanced). Substance abusing adolescents are significantly associated with families at the extreme level of functioning.

Summary of Hypothesis

HO I	Adolescent substance abusers as compared to the adolescent norm group characteristically perceive themselves as disengaged from the family system.	Accept
HO II	Adolescent substance abusers as compared to the adolescent norm group characteristically perceive the relationships within the family systems as being more rigid.	Accept
HO III	Substance abusing adolescents who are COA will significantly perceive the family system as more rigid.	Accept
HO IV	Substance abusing adolescents whose real scores fall into the extreme ranges will have ideal scores falling into the extreme and opposite ranges to their real scores.	Reject

CHAPTER FIVE: DISCUSSION

Chapter five will be discussed under three headings. Firstly the findings based on the hypotheses will be discussed. Secondly, under related findings both related and unexpected findings will be explored, and lastly, the limitations of the study and recommendations for future research will be discussed.

Hypotheses

Cohesion Classification: Disengaged

A family systems approach was used to investigate adolescent substance abusers. The adolescents' perceptions of family functioning were assessed by the FACES II, an instrument specifically designed to capture family systems concepts. In this study, the substance abuser characteristically perceived the family as rigid and disengaged. In other words, the adolescent feels isolated from the family and sees the family as being extremely inflexible.

Feeling emotionally cut-off or disengaged from the family unit was the strongest finding in the study with 83% of the respondents indicating experiencing this type of relationship within the family system. Olson (1993) described the disengaged family as one in which family members "do their own thing", home-base becomes a feeding and sleeping ground and little other family support or interaction is present. Previous research into adolescent substance abuse confirms the powerful correlation between a negative parent-child relationship and teen substance abuse. In fact, in a two year longitudinal study of preadolescence and

adolescence, researchers Brook and Brook (1987), suggested the most important focus of a drug and alcohol prevention program for adolescents should be the creation of an affectionate and non-conflictual parent-child relationship. According to family systems however, issues in adddition to the parent-child relationship need work in order to remedy the disengaged adolescent. From a family systems point of view, the adolescents substance abuse can be both a symptom and a cause of family dysfunction.

The adolescent begins to perceive himself as disengaged within the family system, but he also promotes it. As the adolescent perceives rejection within the conflictual nature of the family relationships, he withdraws and looks to outside sources for support. The more involved he becomes in drugs, the less involved he is in family relationships. According to Kerr and Bowen (1988), the premature state of emotional cut-off or disengagement makes an individual feel independent of the family. The more disengaged the substance abuser becomes, however, the more likely he/she is to move to symptomatic behavior, with substance abuse homeostatic to the family's functioning. Stanton and Todd (1982) refer to substance abuse and dependency as promoting pseudoindividuation. The substance use distances the child from the family (implying separation), while also supplying enough conflict and crisis over the substance abuse to keep the family focusing on the identified patient. This behavior maintains a system of interaction that keeps the family in a dysfunctional state of balance.

As discussed, the cohesion scale of the FACES II measures family togetherness wherein a disengaged position represents the lowest point on this scale, suggesting extreme separateness within the family system.

Given the degree of disengagement as evidenced by the real scores of this study, one explanation offered is that the adolescent substance abuser would have over-compensated in reporting on what he/she wanted family functioning to be like on the ideal scores. However, given the opportunity to express their ideal degree of family togetherness, the adolescents in this sample had a choice of moving up three more levels. They moved up only one level, however, to the separated category. The reasons for this became more clear upon reading the notes the adolescents wrote on the response sheets. Some spoiled their responses by writing on the questionnaire in big letters, "I never want to see my family again", or "my family sucks", or "if my Dad didn't hit my Mum ..." Discussion with the counsellors who administered the questionnaire, revealed that many of the adolescents may have felt resentment about their families. Their families had caused them a lot of pain and the adolescent's may not have felt very close to them at that point in time.

Perhaps the adolescents' responses on the ideal scores can help to partially explain their position on the real scores. It appears these adolescents were in troubled family systems where marital and parent-child conflict were common. When given the choice to be closer to the family system, these children chose to remain at a distance. Perhaps the disengaged scores suggest a reactive and protective distancing on the adolescent's part. Berlin, Davis and Orentein (1988) entertain the idea that adolescents from alcoholic families will try to distance themselves from a painful family environment. The authors explain how there are two ways in which adolescents may distance themselves, one way is healthy (called adaptive distancing) and the other is detrimental (called reactive distancing). Both types flee the family toward activities and relationships.

While adaptive distancer's choose positive activities and relationships outside the family, reactive distancer's cope by denying their own distress, minimizing their feelings and by choosing delinquent, impulsive peers who allow them to substitute "action" in place of coming to terms with their feelings.

Adaptability Classification: Rigid

According to Olson (1993) the more extreme functioning families will usually show more family problems or symptom behaviors. Consistent with Olson's findings, adolescent substance abuse in this study was strongly associated with extreme scores. In this sample, 69% showed extreme functioning in terms of rigid or very inflexible families.

Carter and McGoldrick (1989) discussed the immense changes that adolescence generates and the need for families to maintain flexibility in order to successfully pass through this stage. Kerr and Bowen (1988) maintained that healthy people and healthy families are those that have individuated, or support individuation. The authors explained how the more individuated a family is, the more flexible family members will be.

Ackerman (1958) considered how adolescent psychopathology is actually one symptom of a larger family pathology. He suggested that adolescent problems are related to inflexible families. He described the violence of the adolescent revolt as being in direct proportion to the amount of resistance exhibited by the parents. In a similar vein, Minuchin (1974) relates inflexible families to problem behaviors. The author explained that symptomatic families remain stuck, using a symptomatic member to avoid change while normal families are able to change and do not require such a sacrifice.

Research supports the hypothesis that more healthy families are more flexible. De Forest (1974), found when comparing the parents of adolescent substance users and non-users, the non-user parents showed more flexibility with respect to role changes. That is, both parents could accommodate to situations requiring a role switch, such as a mother who becomes the breadwinner, and a father as the nurturer. In short, authors and researchers agree that inflexible family systems are associated with more difficulties, especially during adolescence; the findings of this study support this perspective.

Rigid family relationships exist when one individual is in charge and is highly controlling (Olson, 1993). Adolescents in this study perceived the family as extremely rigid and therefore highly controlling. The adolescents' counsellors in this sample reported that the adolescents may feel like everyone else is in control of their lives, to the extent that if they become involved with the law, it is not their fault but "the stupid officer who arrested them". The counsellors explained that it is often difficult for their adolescent clients to understand how they (the adolescents) are personally responsible for their own behavior. In addition, as the parents attempt to control or limit the adolescent's substance abusing behavior, the adolescent perceives this action as just another example of someone else trying to control their life. The adolescent may resent what they perceive to be authority interference and as the parents become involved with the child's substance problem the adolescent's perception of a rigid family system increases (Noller & Callan, 1986; Olson, 1993).

The adolescents' rigid perceptions of family functioning support the counsellor reports that the young substance abuser has difficulty taking responsibility for his or her own behavior. Rigid family systems

correspond with authoritarian parenting which suggests that the parents allow the adolescent little if any input regarding family decision-making. Research indicates that authoritarian parenting styles have difficulty imparting a feeling in adolescents that they are responsible for their actions. This parenting style has been associated with the development of an external locus of control in children (Pardeck & Pardeck 1990). That is, adolescents perceive control over themselves as coming mostly from outside sources. Not surprizingly, adolescent substance abuse has been associated with external rather than internal locus of control (Coombs, 1988)

The circular nature of the adolescent's perception of a rigid family system can be seen from the above examples. Both the parents and the adolescent can contribute to the rigid nature of a family system. The parents may indeed be involved with creating a rigid family system. However, rebelling adolescents may view nearly all input from adult figures as controlling, even when the parents are being reasonable. Adolescents who believe that other people have more control over their actions than they do will most likely perceive a family system as rigid (Noller & Callan, 1986; Olson, 1993).

Extreme Scores: Rigid and Disengaged

The combination of a rigid and disengaged family type found in this study is consistent with other reports on adolescent (Friedman et al., 1987), and young adult (Williamson, 1986) substance abusers' perceptions of family functioning. However, the results of this study were significantly stronger. Both Friedman (1987) and Willamson (1986), using the FACES II, found 42% of their samples to be rigid and

disengaged, while the present study found 62% of this family type. Perhaps the more extreme scores of this sample could be related to the adolescents' living arrangements (ie. 28% of the subjects in this sample did not live with their parents). While it is unclear in the other studies if some adolescents lived outside the home, it did account for the more extreme scores in this study.

It is not known why some of the adolescents in this study were not living with their parents. Statistics indicate parent-child conflict is a common reason for placing adolescents outside of the home (Coombs, 1988) either in social services care or in living situations with other family members. If the parent-child relationship deteriorated enough that the child must live out of the home, it is in all likelihood reflected in the scores.

COA and Non-COA Substance Abusers

Children from alcoholic homes (COA's) in this study had more extreme scores than the non-COA on the adaptability dimension. Consistent with alcoholic family systems research, the COA in this study experienced a rigid family; a family where roles and rules are inflexible. However, it is important to note that COA's and non-COA's differed only in terms of degree and not on type of family system, specifically, they both perceived the family as rigid, but the COA's were more so.

Thirty-three percent (33%) of the subjects in the study represented the COA grouping which was higher than the normal population (Lawson & Lawson, 1989). These findings are consistent with previous research which indicated that alcoholic families are more likely to produce

substance abusers than the non-alcoholic family system (Holland & Griffin, 1984).

Related Findings

Related Findings

There was no difference in the family functioning scores with relation to the type of substance used. Adolescents abusing only alcohol or marijuana, or those abusing a combination of drugs, showed no differences on their scores. Research suggests that it is the nature of the abuse and not the drug that creates interpersonal and family problems (Kaufman, 1985).

It is interesting to note that although the type of substance has no effect on perceptions of family functioning, the extent to which an adolescent abuses a substance does have an effect. Substance abusers whose CAGE scores indicated dependency (which is a more severe form of abuse), had more extreme scores of family functioning. This would tend to support Olson's (1993) hypothesis that the more extreme families show more symptomatic behavior. In addition, the substance dependent CAGE scores were more closely associated with the COA status. In other words, COA's tended to have a more debilitating relationship with their substances than the non-COA abusers.

There could be several explanations for the increased CAGE scores associated with the COA status. Research indicates that whether it is family systems, genetics or parental modeling, children from alcoholic families have less ability to cope with alcohol and drugs. The COA substance user is more susceptible to dependency than the non-COA

user. Also, more rigid families have been associated with alcoholic families and the notion that the more inflexible the family, the bigger the wrench needed to pry one loose from an imbalanced family system. This concept could apply to the present study.

Unexpected Findings

The following section will explore three unexpected findings of the study and their implications; a high percentage of females, a high percentage of parents that are abstainers (from alcohol), and the young age of the subjects (16.5 yrs).

An unexpected finding was the high percentage of females (50% of the subjects). Previous research into adolescent substance abuse contained a small percentage of females in the samples used and at times, females were absent from the study. Researchers explain that the clinics they derive the samples from, and even the random sampling of non-clinical populations, usually produce a lower ratio of female to male substance abusers. Even though this study showed no differences between the male and females scores, the information it provides is still worthy of note. Many researchers have had to limit their findings to the male population because the female population could not be accessed. The findings of this study suggest that there are no differences between male and female substance abusing adolescent's perceptions of family functioning.

The drinking habits of the adolescents' parents in this study where broken down into three groups; heavy drinkers (producing COA status), moderate drinkers, and abstinent parents. The abstinent parents led the group by representing 43% of the adolescents' parents, followed by the

heavy drinkers at 33%, and finally the moderate drinking parents at 24%. It is interesting to note that adolescent substance abuse is correlated most with heavy drinking parents, and next with abstaining parents (Lawson, Peterson & Lawson, 1983). Theory suggests that abstaining parents are moralistic and rigid in their tolerance for behavior that deviates from their rules, and the findings of this sample would support this rigid type of family thinking.

Whether the adolescents have heavy drinking parents or abstaining parents, both types of adolescents experience extremes in parent role modeling. The extreme drinking habits of the parents do not provide the adolescents with examples of moderate drinking. The adolescents, consequently, are familiar with either taking drugs to excess, or not tolerating drugs at all. Either option proves difficult for a teen in the 90's where substance use has become a social norm.

The average age for this sample was 16.5 years. It was surprising to find this group so young when previous research of adolescent substance abuse usually involved an older age group referred to as late adolescence (approximately 18 to 19 years of age). The clinic sample used in this study appears similar to other day-treatment groups used for research. The clinic itself provides counselling services and activities for the adolescents and their families, and while most adolescents are referred by school, family or self, a small number are court referred.

Although age accounted for a difference in some of the scores, there was no apparent consistency in this, nor a logical pattern. According to Noller and Callan (1986), adolescents scores on the FACES II lean more to mid-range and away from balanced, the older they become. They also state, that adolescents are less likely to desire really close family

relationships for their family ideal. While Noller and Callan's findings refer to normal adolescents, they explain that it is the stage of adolescence that causes the scores to fall away from a balanced range. In applying these research findings to substance abusing adolescents, one might expect to find even stronger extreme scores with an increase in age. However, a consistent pattern was not found in this study, and the differences in age related scores may therefore be attributed to natural statistical deviations.

Limitations and Recommendations

This study employed a causal-comparative method assessing adolescent substance abusers from day treatment programs using a norm group in place of a control group. The norm group was used for several reasons. Firstly, when control groups have been used in previous research on substance abusing and non-substance abusing adolescents, the findings indicated no significant differences between the control group and the norm group (Smart, Chibucos, & Didder, 1990; Williamson, 1986). Secondly, the FACES II has been used extensively in over 5000 studies showing consistency in the normal population for both adolescents and adults. Finally, gaining access to the school system as a means to obtain an adolescent control group requires government approval and is extremely difficult to obtain. Hence, while the findings of this study can not be generalized to all substance abusing adolescents, they can however add support to previous research and suggest avenues for further exploration.

The data collection procedure employed produced only four spoiled responses out of 46. In retrospect, it is possible that some of the Likert

scale responses may have been confusing for some adolescents. Extremely reactive adolescents, such as those that felt very negative about their families, may have assumed that a response of "1" (almost never) was the most negative answer possible, and without reading each question carefully, wrote a "1" at the top of the page and drew an arrow all the way down indicating "1" response for each answer. However, if they read carefully they would have found that in some questions, the "1" produces the most positive family condition and the "5" the most negative. In future studies, this problem could be over come by having the administrator explain that "1" does not necessarily imply the most negative answer for all questions.

The COA group in this study was measured using the single item Children from Alcoholic Famlies (CAF). In using a single item method the researcher risks accuracy (Galanter, 1991). There are, however, more in-depth methods of assessing COA status. One such method is using the questionnaire technique CAST or the Children of Alcoholics Screening Test. The CAST consists of 30 dichotomous items (Litterell, 1991). For the purpose of this study's design, however, the single item CAF was chosen in order to increase the number of returns. Adding the 30 item CAST may have made this questionnaire package too long for these participants and therefore would have diminished the returns.

Finally, reading the graffiti written on the questionnaires, and speaking with the adolescent's counsellors, this researcher wonders if the extreme scores on the FACES II were a measure of the anger and resentment many of these participants were feeling towards their families. While these adolescents obviously experienced rigid and disengaged families, the question to be asked is, did they experience them to such a

considerable extent? Is the pain of living in a troubled family causing these adolescents to respond on the FACES II in a particulary reactive fashion?

Recommendations

Based on the findings of this study it became apparent to the researcher that further investigation would be beneficial.

1. Only the adolescents' perceptions of family functioning were used in this study. A more definitive application of FACES II would include the perceptions of family members. While several researchers have studied adolescents and their parents (Friedman, Utada, & Morrissey, 1987; Smart et al., 1990), none have explored the siblings perceptions extensively.
2. Family functioning was only measured on the FACES II and thus cannot be said to have been examined fully. A broader investigative approach such as combining in-depth interviews utilizing a phenomenological approach with the FACES II appears warrented.
3. Designing a study that takes into consideration reactive responses. For example, correlating rigid and disengaged scores with measures that tap the amount of pain, anger and resentment felt by participants due to family situations.
4. Designing a study that uses more extensive COA measures, and includes more COA subjects.
5. Exploring abstaining families of non-substance abusing adolescents with abstaining families of substance abusing

adolescents. How might these samples respond with regard to the FACES II.

Based on the findings, suggestions for counsellors, teachers or any individuals working with substance abusing adolescents could be made. More specifically these findings could be generalized to the following group: adolescents who abuse a variety of soft drugs such as alcohol and marijuana; middle-aged adolescents (15 to 17 age group); middle to lower middle socio-economic class in a metropolitan area; and to both males and females.

Substance abusing adolescents who feel there is very low flexibility in their families will also tend to feel that they do not have much influence over what happens to them. These adolescents may be unaccustomed to being a part of a decision-making process at a family level. Also, they may tend to feel that authority figures hold most of the power and that they have little control over their lives. As a result of the above adolescent perceptions, adolescents may have difficulty feeling responsible for their own behavior.

Counsellors working with such teens would need to be aware of how they might increase the adolescents' perceptions of control. Providing choices and involving the adolescents in the decision-making process concerning circumstances which involve them are techniques that could be used. For example, having adolescents set limits on their own behavior, such as appropriate times to be home, and involving the teens in their own discipline by allowing them to set the consequences would help increase the adolescents feelings of control.

Counsellors working with substance abusers and their families will first need to observe the family interaction patterns. If the adolescents

perceptions of a rigid family are similar to the adolescents, then the counsellor might decide to teach communication skills. Rigid families tend to have poor communication. The one-way communication processes characteristic of rigid families suggests while one family member has most of the power and input, the other family members have little influence. Once two-way communication has been established, the counsellor could work on how the family can all be involved in negotiations and problem-solving. Problem-solving would best be approached from an experimental view point. Decisions that are seen as experiments are tentative until they are proven that they work (and still there is room for change). The family needs to know that decisions do not have to be permanent and that it is alright to change the plans along the way.

Substance abusing adolescents who feel there is little family togetherness may be feeling isolated in the family. Once issues of family physical or sexual abuse have been ruled out, the counsellor may work on promoting connectedness within the family, such as through shared problem-solving. Planning an evening out or even something as simple as finding a program on the TV. that everyone can watch would be a step in bringing the family together. It is important to note that families or individuals who score in the extreme ranges of cohesion and adaptability need to move slowly towards more balanced means of interaction. Steps towards family flexibility and connectedness should be small.

Counsellors and teachers working with adolescents who they know or believe to be substance abusers can help the adolescents focus on more positive activities. The counsellor needs to find activities that can replace the social acceptance and sense of mastery which the drug-using lifestyle

provides. Exploring hobbies or finding school subjects that the adolescent is interested in and feels capable of mastering is a step towards substituting a negative lifestyle with a positive one.

Summary

Adolescent substance abusers in this study perceived their families as rigid and disengaged on the FACES II. While both COA and non-COA substance abusers scores fell in the extreme range, the COA scores for rigid family systems were even more extreme than the non-COA substance abuser. There were no differences between the male and female subjects, and no differences for the type of substance used by the adolescents. Those who were substance dependent (as measured by the CAGE) showed more extreme scores, indicating greater family imbalances. A significant percentage of adolescents in this study had parents who were abstainers or heavy drinkers.

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APPENDIX A: Cage Questionnaire

The CAGE Questionnaire *

1. Have you ever felt you ought to **C**ut down on your drinking or drug use?
2. Have people **A**nnoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or **G**uilty about your drinking or drug use?
4. Have you ever had a drink or drugs first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)

* Source: Journal of The American Medical Association (1984) Vol 252, No. 14

APPENDIX B: DSM IV Definition of Substance Abuse / Dependence

DSM-IV DEFINITION OF SUBSTANCE ABUSE / DEPENDENCE

The revised fourth edition of the American Psychiatric Association's (APA, 1994) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines "abuse" as a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems (Criterion A). These problems must occur recurrently during the same 12 month period. Unlike the criteria for Substance Dependence, the criteria for Substance Abuse do not include tolerance, withdrawal, or a pattern of compulsive use and instead include only the harmful consequences of repeated use. A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has ever met the criteria for Dependence for that class of substances (Criterion B).

The APA (1994, pp. 181) defines the Criteria for Substance Dependence as:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12 month period:

(1) tolerance, as defined by either of the following:

  (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect.

  (b) markedly diminished effect with continued use of he same amount of the substance.

(2) withdrawal, as manifested by either of the following:

  (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances).

  (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) the substance is often taken in larger amounts or over a longer period than was intended.

(4) there is a persistent desire or unsuccessful effort to cut down or control substance use.

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., chain smoking), or recover from its effects.

(6) important social, occupational, or recreational activities are given up or reduced because of substance abuse.

(7) the substance use is continued despite knowledge of having a persistent or recurrent physicai or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine induced depressions, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

APPENDIX C: Circumplex Model and Faces II Concepts

	Rigid	Structured	Flexible	Chaotic
LEADERSHIP	Authoritarian leadership. Parent(s) high controlling.	Primarily authoritarian but some equalitarian leadership.	Equalitarian leadership with fluid changes.	Limited and/or erratic leadership. Parental control unsuccessful. Rebuffed.
DISCIPLINE (For families only)	Autocratic "law and order." Strict rigid consequences. Not lenient.	Somewhat democratic. Predictable consequences. Seldom lenient.	Usually democratic. Negotiated consequences. Somewhat lenient.	Laissez-faire and ineffective. Inconsistent consequences. Very lenient.
NEGOTIATION	Limited negotiations. Decisions imposed by parents.	Structured negotiations. Decisions made by parents.	Flexible negotiations. Agreed upon decisions.	Endless negotiations. Impulsive decisions.
ROLES	Limited repertoire. Strictly defined roles. Unchanging routines.	Roles stable, but may be shared.	Role sharing and making. Fluid changes of roles.	Lack of role clarity. Role shifts and role reversals. Few routines.
RULES	Unchanging rules. Rules strictly enforced.	Few rule changes. Rules firmly enforced.	Some rule changes. Rules flexibly enforced.	Frequent rule changes. Rules inconsistently enforced.

Family Flexibility

	Disengaged	Separated	Connected	Enmeshed
EMOTIONAL BONDING	Extreme emotional separateness. Lack of family loyalty	Emotional separateness. Limited closeness. Occasional family loyalty.	Emotional closeness. Some separateness. Loyalty to family expected.	Extreme emotional closeness. Little separateness. Loyalty of family demanded.
FAMILY INVOLVEMENT	Very low involvement or interaction. Infrequent affective responses.	Involvement acceptable. Personal distance preferred. Some affective responsiveness.	Involvement emphasized. Personal distance allowed. Affective interactions encouraged and preferred.	Very high involvement. Fusion, over-dependency. High affective responsiveness and control.
MARITAL RELATIONSHIP	High emotional separateness. Limited closeness.	Emotional separateness. Some closeness	Emotional closeness. Some separateness.	Extreme closeness, fusion. Limited separateness.
PARENT-CHILD RELATIONSHIP	Rigid generational boundaries. Low p/c closeness.	Clear generational boundaries. Some p/c closeness.	Clear generational boundaries. High p/c closeness.	Lack of generational boundaries. Excessive p/c closeness.
INTERNAL BOUNDARIES **TIME** (Physical and Emotional) **SPACE** (Physical and Emotional) **DECISION-MAKING**	**Separateness dominates.** Time apart maximized. Rarely time together. Separate space needed and preferred. Individual decision making. (oppositional)	**More separateness than togetherness.** Time alone important. Some time together. Separate space preferred. Sharing of family space. Individual decision making, but joint possible.	**More togetherness than separateness.** Time together important. Time alone permitted. Sharing family space. Private space respected. Joint decisions preferred.	**Togetherness dominates.** Time together maximized. Little time alone together. Little private space permitted. Decisions subject to wishes of entire group.
EXTERNAL BOUNDARIES **FRIENDS** **INTERESTS** **ACTIVITIES**	**Mainly focused outside the family.** Individual friends seen alone. Disparate interests. Mainly separate activities.	**More focused outside than inside family.** Individual friendships seldom shared with family. Separate interests. More separate than shared activities.	**More focused inside than outside family.** Individual friendships shared with family. Some joint interests. More shared than individual activities.	**Mainly focused inside the family.** Family friends preferred. Limited individual friends. Joint interests mandated. Separate activities seen as disloyal.

Family Cohesion

COHESION

ADAPTABILITY	DISENGAGED	SEPARATED	CONNECTED	ENMESHED
CHAOTIC	0% (1%)	0% (3%)	0% (6%)	0% (11%)
FLEXIBLE	5% (2%)	2% (9%)	7% (11%)	0% (7%)
STRUCTURED	17% (8%)	2% (14%)	0% (12%)	0% (2%)
RIGID	62% (7%)	5% (6%)	0% (1%)	0% (0%)

Percentages of Adolescent Drug Abusers found within the 16 Family Types

(Norm group show in brackets)

Family Typology

COHESION		
8	80 – 74	Enmeshed (very connected)
7	73 – 71	
6	70 – 65	Connected
5	64 – 60	
4	59 – 55	Separated
3	54 – 51	
2	50 – 35	Disengaged
1	34 – 15	

ADAPTABILITY		
8	70 – 65	Chaotic (very flexible)
7	64 – 55	
6	54 – 50	Flexible
5	49 – 46	
4	45 – 43	Structured
3	42 – 40	
2	39 – 30	Rigid
1	29 – 15	

Faces II Linear Interpretation

	Mean	SD	Range
Cohesion	56.3	9.2	15-70
Adaptability	45.4	7.9	15-70

Adolescents (n= 416)

Faces II Norm Group Means

APPENDIX D: Questionnaire

Faculty of Education
Department of Educational Psychology
6-102 Education North
University of Alberta
Edmonton, Alberta. T6G 2G5

Dear Parent/Guardian:

Teresa Cowan of the Educational Psychology Department at the University of Alberta will be conducting a study involving adolescents and their families under the supervision of Dr. Don Sawatzky. More specifically we are concerned with the adolescent's perception of their family. Each person views their family from a particular perspective and we are interested in how adolescents from drug and alcohol treatment programs and support groups perceive their family.

The study involves your child to fill out a questionnaire that is easily completed in 20 minutes and requires no written answers. Neither you nor your child's name will appear on any of the questionnaires and all information is completely confidential. By participating, you will be assisting us to help other adolescents and their families through the information your child provides in the study. Participation is voluntary and your child may withdraw from the study at any time without any consequences.

Respectfully,

Teresa Cowan
Graduate Student

Dr. Don Sawatzky
Professor of Education Psychology

INSTRUCTIONS FOR THE COUNSELLORS

**** Please keep all the forms stapled together !!! *****

There will be **4 forms** for the adolescents **to fill out and hand in:**
1) PART A - Consent Form
2) PART B - FACES II : How You Presently View Your Family
3) PART C - FACES II : How You Would Like To See Your Family
4) PART D - Family Demographics

** Note
- If they **live with two families**, they should respond to the family they live with the most or the family they feel the strongest about.
- Filling out all 4 forms will take approximately 45 minutes. If a **group setting** is being used, please explain Part A Consent Form first and sign it. Once Part A has been completed, please go through Parts B, C, and D, with the adolsecents explaining what they are to answer with each. Then let them proceed at their own pace.

STEP 1: PART A - Consent Form

1. **Hand out** the package of Forms A, B, C, and D
a) **Explain** that this is a study of how adolescents from drug and alcohol programs view (perceive or see) their family. We would like to know what their thoughts on their family are.
b) **Explain** that they will fill out a questionnaire asking them:
i) How they view or perceive their families now.
ii) How they would like to see their family.

2. **Read out loud** the consent form to them.
Please emphasize that this is strictly confidential, that not even the counsellors will be given access to the questionnaires.

3. Ask them to **sign** the form.

STEP 2 : PART B, C, AND D

1. PART B - FACES II : Ask the adolescents to fill it in. **How you presently view your family ?** How frequently that behavior occurs ? Choose a number from the above range of 1-5 which best describes your family.
2. PART C - FACES II: Ask the adolescents to fill it in. **How you would like to see your family ?**
3. PART D - FAMILY DEMOGRAPHICS. This is statistical information that will be used in the calculations of the study.

PART A "CONSENT FORM"

Faculty of Education
Department of Educational Psychology
6-102 Education North
University of Alberta
Edmonton, Alberta. T6G 2G5

Dear Participant:

Teresa Cowan of the Educational Psychology Department at the University of Alberta will be conducting a study involving adolescents and their families under the supervision of Dr. Don Sawatzky. More specifically we are concerned with the adolescent's perception of their family.

Each person sees their family from a particular viewpoint and we are interested in how adolescents from drug and alcohol treatment programs and support groups perceive their family.

The study will ask you to fill out a questionnaire that is easily completed in 20 minutes. Your name will not appear on any of the questionnaires and all information is completely confidential. By participating, you will be assisting us to help other adolescents and their families through the information you provide in the study. Participation is voluntary and you may withdraw from the study at any time without any consequences.

Please complete the bottom portion of this form and return it to your counsellor or group leader. Please call Teresa Cowan in Vancouver at 264-0162 if you have any questions. Thank you, in advance for your time.

Respectfully,

Teresa Cowan	Dr. Don Sawatzky
Graduate Student	Professor of Education Psychology

****

Please check your response:

___ I DO wish to participate in the adolescents' perception study.
___ I DO NOT wish to participate in the adolescents' perception study.

Signature: _____

Date signed: _____ _____

FACES II: Family Version

David H. Olson, Joyce Portner & Richard Bell

1 Almost Never	2 Once in Awhile	3 Sometimes	4 Frequently	5 Almost Always

Describe Your Family:

___ 1. Family members are supportive of each other during difficult times.
___ 2. In our family, it is easy for everyone to express his/her opinion.
___ 3. It is easier to discuss problems with people outside the family than with other family members.
___ 4. Each family member has input regarding major family decisions.
___ 5. Our family gathers together in the same room.
___ 6. Children have a say in their discipline.
___ 7. Our family does things together.
___ 8. Family members discuss problems and feel good about the solutions.
___ 9. In our family, everyone goes his/her own way.
___ 10. We shift household responsibilities from person to person.
___ 11. Family members know each other's close friends.
___ 12. It is hard to know what the rules are in our family.
___ 13. Family members consult other family members on personal decisions.
___ 14. Family members say what they want.
___ 15. We have difficulty thinking of things to do as a family.
___ 16. In solving problems, the children's suggestions are followed.
___ 17. Family members feel very close to each other.
___ 18. Discipline is fair in our family.
___ 19. Family members feel closer to people outside the family than to other family members.
___ 20. Our family tries new ways of dealing with problems.
___ 21. Family members go along with what the family decides to do.
___ 22. In our family, everyone shares responsibilities.
___ 23. Family members like to spend their free time with each other.
___ 24. It is difficult to get a rule changed in our family.
___ 25. Family members avoid each other at home.
___ 26. When problems arise, we compromise.
___ 27. We approve of each other's friends.
___ 28. Family members are afraid to say what is on their minds.
___ 29. Family members pair up rather than do things as a total family.
___ 30. Family members share interests and hobbies with each other.

✓

FACES II: Family Version

David H. Olson, Joyce Portner & Richard Bell

1 Almost Never	2 Once in Awhile	3 Sometimes	4 Frequently	5 Almost Always

Describe Your Family:

___ 1. Family members are supportive of each other during difficult times.
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___ 7. Our family does things together.
___ 8. Family members discuss problems and feel good about the solutions.
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___ 13. Family members consult other family members on personal decisions.
___ 14. Family members say what they want.
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___ 27. We approve of each other's friends.
___ 28. Family members are afraid to say what is on their minds.
___ 29. Family members pair up rather than do things as a total family.
___ 30. Family members share interests and hobbies with each other.

✓

PART D "FAMILY DEMOGRAPHICS"

FAMILY STUDY CONFIDENTIAL

Please answer all questions. The data you supply will help to complete a study on how families function.

1. Age: _____ 2. Sex: Male _____ Female _____

3. Have you ever wished that either one or both of your parents would drink less?

a) ____ Parents don't drink at all
b) ____ Yes
c) ____ No

4. What is your father's occupation:

_____

_____

(Be specific eg. School Bus Driver, Department Store Appliance Repairman, Elementary School Teacher)

5. Your Father is ?

a) Employed by (type of company) _____
b) Self employed _____ (eg. Computer Sales)
c) Currently unemployed _____

6. What is your Mother's occupation ?

_____

_____

(Be specific eg. Housewife, Hospital Nurse, Child Psychologist, Supermarket Cashier)

7. Your Mother is ?

a) Employed by (type of company) _____
b) Self employed _____ (eg. Department Store)
c) Currently unemployed _____

8. Do you live at home ?

a) Yes _____
b) Left home less than 18 months ago _____
c) Left home more than 18 months ago _____

PART D "FAMILY DEMOGRAPHICS"

9. Please circle which drug you most commoniy use:

   a) Alcohol
   b) Other drugs (Marijuana, LSD, amphetamines, PCP, cocaine, etc.)
   c) Use alcohol and other drugs about the same amount

10. Have you ever felt you ought to cut down on your drinking or drug use ?

    a) Yes _____
    b) No _____

11. Have people annoyed you by criticizing your drinking or drug use ?

    a) Yes _____
    b) No _____

12. Have you ever felt bad or guilty about your drinking or drug use ?

    a) Yes _____
    b) No _____

13. Have you ever had a drink or used other drugs first thing in the morning to steady your nerves and get rid of a hangover? ("eye-opener")

    a) Yes _____
    b) No _____

14. Has drinking or drug use placed you in trouble with family, friends or the law?

    a) Yes _____
    b) No _____

Thanks for your cooperation

APPENDIX E: Raw Scores

Subjects >>>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Coa	C	C	C	C	C	C														C	
Abstinent or Moderate							A	A	A	A	A	A	A	A	A	M	M	M	M		M
Age	18	18	15	16	17	14	15	16	17	17	16	17	18	17	16	18	15	15	15	17	15
Sex	M	F	F	M	M	F	M	F	F	F	F	F	M	F	F	F	M	M	F	M	F
Cage	4	3	2	3	0	3	1	1	0	4	1	1	2	3	2	4	2	0	2	2	2
Rigid/Disengaged	Y	Y		Y	Y	Y			Y	Y				Y	Y		Y		Y	Y	Y
Type of Dependency	D	A	A	D	A	D	D	D	A	D	A	A	A/D	A	D	D	A/D	D	A	D	A
Lives at home	H	H	H	H	H		H		H	H	H	H			H	H	H	H	H		H

Subjects (continued) >>>	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
Coa	C					C	C							C		C		C		C	
Abstinent or Moderate		M	M	A	A			A	A	A	A	M	M		A		A		M		A
Age	16	18	16	16	15	16	16	15	15	18	21	15	19	20	18	17	15	17	15	16	19
Sex	F	M	F	M	F	M	M	M	M	M	M	F	F	M	F	F	M	M	M	F	M
Cage	2	4	1	2	1	3	1	2	2	4	2	2	3	2	1	0	2	3	0	4	2
Rigid/Disengaged		Y	Y		Y		Y		Y	Y	Y	Y	Y			Y		Y		Y	Y
Type of Dependency	D	D	A/D	D	A/D	A/D	A	D	D	D	A	D	A/D	A	A	A	D	A	D	A	A
Lives at home		H	H	H		H	H	H		H		H		H	H	H	H	H	H		

Raw Scores: Subject Profiles

Subject >>>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
Question 1	3	1	5	5	1	1	5	2	2	2	5	5	2	1	2	5	3	2	1	3	4	1	4	1	3	2	4	4	5	2	5	2	3	2	3	5	1	2	1	2	1	3
2	2	1	3	2	1	1	3	2	5	1	3	4	4	1	1	3	4	1	1	2	4	3	3	1	3	5	4	3	3	5	2	2	4	1	2	2	1	3	1	2	1	2
3	4	5	5	5	5	5	5	3	5	5	5	3	5	5	5	2	4	4	5	5	4	5	5	5	4	5	2	3	4	3	4	5	3	5	5	5	5	4	5	4	5	5
4	2	2	3	3	1	1	3	1	3	2	4	5	3	1	2	4	4	3	2	1	1	3	2	2	4	5	3	2	4	1	3	2	3	2	2	3	2	3	2	3	1	2
5	1	1	2	1	3	1	3	1	5	1	1	3	5	2	1	3	2	2	1	1	1	2	1	2	3	1	4	1	3	4	2	1	2	1	5	5	3	3	2	3	2	3
6	2	2	3	1	1	1	4	3	1	2	3	3	1	2	1	2	1	5	3	1	1	3	3	3	4	1	5	1	5	5	1	2	2	3	1	3	2	4	2	5	2	2
7	3	1	3	1	1	1	4	1	2	2	4	2	1	1	3	3	3	1	1	2	1	2	2	2	2	3	1	2	3	4	3	1	2	1	4	4	1	2	1	1	3	1
8	2	2	2	2	1	1	4	2	2	1	3	3	1	1	1	4	2	3	2	1	1	2	1	1	3	1	4	2	2	2	4	1	3	3	2	4	1	2	2	3	1	1
9	2	5	4	5	5	5	3	5	5	3	4	3	2	5	4	3	4	5	4	4	3	5	3	5	3	4	5	4	4	3	5	5	4	5	3	4	5	3	5	5	5	5
10	2	1	1	1	4	1	3	5	1	1	4	2	3	2	2	4	1	1	2	1	2	2	1	3	3	2	5	2	3	2	2	1	1	1	2	4	4	3	1	1	2	1
11	2	2	5	5	2	1	4	3	5	1	3	5	1	1	3	5	4	5	4	2	4	3	1	3	2	1	5	5	3	2	1	1	2	4	5	5	2	2	2	4	1	2
12	3	4	1	4	1	3	3	4	1	1	1	2	1	2	1	1	2	2	3	3	1	2	1	4	3	2	1	1	4	4	3	2	1	1	1	4	1	3	4	2	2	2
13	4	2	5	1	1	1	3	3	4	1	1	3	2	2	1	3	4	1	1	2	1	1	1	1	3	2	2	2	3	3	4	1	1	4	3	3	1	3	2	1	2	1
14	4	2	3	4	1	1	4	5	2	2	5	5	5	3	4	5	3	5	2	1	5	5	2	5	3	5	5	3	5	3	5	1	4	2	3	5	1	2	3	5	3	1
15	5	4	1	5	1	5	2	1	1	5	2	4	1	2	3	3	4	5	5	2	2	3	3	4	3	3	5	3	2	4	4	5	2	5	2	1	2	3	4	5	2	5
16	3	2	4	1	1	1	2	1	1	1	4	4	3	1	1	3	5	3	1	1	1	3	2	1	3	2	2	2	3	3	3	1	3	2	3	3	1	3	2	2	1	1
17	2	1	3	5	1	1	4	2	3	2	3	5	2	2	2	5	4	1	3	1	1	2	1	3	3	1	1	4	4	4	3	1	2	2	4	4	1	3	1	1	2	1
18	2	2	5	1	1	1	2	3	5	1	2	4	3	1	4	5	2	5	2	2	1	3	5	1	3	1	4	3	5	3	3	3	3	3	1	3	3	2	3	2	4	3	1
19	3	5	3	1	5	1	1	4	4	4	4	2	2	5	5	1	5	5	5	1	5	3	3	5	2	5	5	2	2	3	4	5	2	3	3	1	5	4	4	5	5	5
20	2	2	1	1	1	1	2	1	3	1	4	2	1	2	3	4	4	3	3	2	5	3	4	3	3	1	4	2	4	1	4	1	2	2	3	3	1	3	2	3	2	2
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22	3	1	4	1	5	1	3	2	5	1	4	5	4	1	2	5	2	2	3	1	1	3	1	3	3	1	3	4	3	2	2	3	4	1	2	4	5	3	2	2	1	3
23	2	1	3	1	1	1	2	3	2	1	3	3	3	1	1	3	1	1	1	1	1	1	2	1	2	2	2	2	2	3	2	1	1	1	2	4	1	2	1	2	3	1
24	3	3	5	1	4	5	5	2	4	5	3	2	1	4	5	3	4	3	5	1	1	2	3	3	3	1	3	3	1	5	3	2	3	4	3	3	4	3	3	3	4	3
25	1	2	1	5	4	1	1	3	3	4	2	1	4	3	4	1	1	5	4	4	2	4	3	3	3	3	3	3	3	1	4	2	3	5	3	1	4	3	2	5	3	2
26	3	1	5	2	1	5	3	3	2	1	3	3	5	2	1	4	3	3	1	1	2	2	3	1	3	1	3	2	2	3	2	1	3	1	2	3	1	3	1	3	2	1
27	3	2	3	3	1	5	4	1	4	1	2	5	2	1	1	4	1	2	3	1	3	2	2	3	2	1	3	4	4	2	1	1	2	3	3	5	2	2	2	2	1	1
28	5	5	4	1	1	1	2	2	2	5	4	1	3	1	3	1	4	5	1	2	4	4	3	3	1	1	2	1	2	4	4	3	3	3	4	2	1	2	5	5	1	3
29	3	5	3	4	1	2	2	1	3	5	3	2	1	2	3	2	5	1	5	4	1	1	4	5	2	1	4	4	4	3	1	1	3	4	4	2	1	2	5	2	2	2
30	1	1	3	3	1	2	3	2	3	1	3	5	1	1	1	3	5	3	1	2	1	2	1	1	2	1	3	2	5	1	2	1	3	1	5	4	1	2	1	3	1	1
COHESION	41	24	56	37	28	36	57	40	48	24	45	60	41	28	30	63	41	32	27	33	37	33	32	27	44	30	39	46	52	48	40	26	41	30	53	65	26	41	26	32	32	29
ADABTABILITY	34	26	38	33	26	24	41	40	37	17	45	51	42	26	27	52	37	40	31	26	32	40	34	34	46	37	50	35	52	37	39	27	39	26	30	48	29	42	28	40	26	25

Cohesion mean = 38.62 Sd = 11.07

Adaptability mean = 35.50 Sd = 8.55

Raw Scores: Faces II Real

Subject >>>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
Question 1	4	5	3	5	5	5	4	5	5	3	5	5	3	5	4		5	5	5	5	5	4		5	3		4	5	5	5	5	5	4	5	4	5	5	5	5	5	5	5
2	4	5	3	1	5	5	4	5	5	4	3	5	4	5	5		5	4	5	5	5	4		5	5		4	4	3	1	4	4	4	4	4	5	5	5	4	4	5	3
3	3	4	5	1	1	2	4	5	3	3	5	4	2	3	4		5	3	5	2	5	4		3	3		2	2	4	1	2	1	2	3	2	4	3	4	4	3	3	2
4	5	4	3	5	5	5	3	3	4	4	4	5	2	4	4		5	4	5	4	3	3		4	5		5	5	4	5	4	4	4	4	5	5	5	5	4	5	4	4
5	4	1	3	4	5	3	2	2	5	2	1	5	1	3	3		2	3	3	4	1	3		3	3		3	3	3	5	4	4	4	4	5	5	4	3	1	3	3	3
6	4	4	3	5	5	5	3	4	5	4	3	3	1	5	4		3	5	5	5	1	5		5	5		5	4	5	5	3	4	4	3	3	3	5	5	4	5	5	4
7	4	1	3	5	5	3	2	3	3	2	4	5	1	5	3		2	3	3	4	3	3		3	3		2	2	3	5	4	4	3	5	4	5	5	3	1	3	5	4
8	5	4	3	4	5	5	3	3	5	3	3	5	1	5	4		3	5	5	5	3	1		5	3		3	4	2	5	4	4	4	3	5	5	4	3	4	5	5	4
9	5	3	4	5	1	5	3	4	3	3	4	2	3	3	4		3	2	3	2	5	3		3	3		4	3	4	1	2	3	3	1	3	2	1	3	3	3	3	3
10	4	3	2	5	5	5	1	5	1	4	4	5	4	3	3		2	3	4	4	3	5		4	2		2	4	3	5	1	4	1	2	4	5	5	2	3	3	3	4
11	3	3	5	5	5	5	4	5	5	3	3	4	5	3	3		1	5	4	4	3	3		4	3		4	5	3	5	3	4	4	3	4	4	5	3	2	5	3	3
12	2	1	1	5	1	1	3	3	1	3	1	1	5	2	1		5	1	1	1	1	3		2	3		1	1	4	1	1	2	1	4	1	1	1	3	1	1	2	2
13	2	3	4	1	5	2	3	5	5	3	1	2	2	5	2		2	2	1	5	3	5		2	3		4	4	3	3	4	4	4	2	4	2	3	3	3	2	5	4
14	3	4	4	3	5	5	3	5	4	4	5	5	2	5	5		5	5	5	4	5	4		3	3		4	4	5	3	4	5	4	5	4	5	5	4	4	4	5	4
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16	4	5	4	3	5	4	3	5	4	3	4	5	5	3	3		3	5	5	5	5	4		4	3		5	4	3	4	4	3	4	5	4	5	4	4	5	5	3	3
17	5	3	4	5	5	4	3	4	5	3	3	5	1	4	4		3	3	3	5	3	3		4	3		4	4	4	5	4	5	4	5	4	5	5	3	3	3	4	5
18	5	5	4	5	5	5	2	4	5	4	2	5	2	2	5		4	5	5	4	1	3		4	3		5	5	5	4	5	5	4	5	4	5	5	5	5	5	2	5
19	3	3	3	1	1	4	3	2	2	3	4	4	5	1	3		5	4	3	2	5	4		3	3		3	2	2	3	1	2	2	1	3	4	4	3	3	4	1	2
20	4	5	4	4	5	4	3	3	5	3	4	5	3	5	3		3	4	5	4	3	5		4	3		2	3	4	3	4	4	4	5	3	5	5	3	5	4	5	4
21	2	3	3	3	5	3	2	3	3	2	4	3	2	5	3		3	4	5	4	3	5		4	3		4	4	3	4	2	4	4	4	4	3	5	3	3	4	5	4
22	3	3	3	5	5	5	2	5	5	5	4	5	1	5	4		3	5	4	4	2	3		3	3		4	5	3	2	4	4	4	4	4	5	5	3	4	5	5	4
23	4	3	4	3	5	2	3	4	3	2	3	4	1	3	3		1	2	2	5	2	4		2	3		3	3	4	4	4	4	3	5	3	4	5	3	3	2	3	3
24	2	2	2	1	1	1	5	3	1	2	3	2	5	3	2		3	1	1	1	1	1		2	3		5	2	3	3	2	3	3	1	2	2	1	3	2	1	3	3
25	2	2	1	1	1	1	3	2	1	3	2	1	2	3	1		5	3	2	1	3	4		2	3		3	2	2	1	1	1	2	1	4	1	2	2	2	3	3	2
26	5	4	5	5	5	5	3	5	5	4	3	5	1	2	4		3	5	4	4	3	3		4	3		4	4	3	3	4	5	4	5	3	5	4	5	3	4	5	2
27	5	4	5	5	5	5	3	5	5	2	2	4	1	1	5		5	1	5	4	4	3		3	3		5	5	5	3	4	4	4	3	5	4	5	3	4	2	1	4
28	2	1	2	1	1	1	3	4	1	3	4	1	4	3	1		1	1	1	1	4	5		2	3		2	1	2	3	1	2	1	1	2	1	1	4	1	1	3	2
29	3	3	4	1	1	2	3	4	1	2	3	3	1	3	3		5	3	2	1	4	4		3	3		4	3	4	1	2	4	2	1	3	3	3	3	3	3	3	4
30	3	3	3	5	5	1	3	5	5	2	3	4	2	5	4		3	2	2	4	1	4		3	3		4	4	5	3	4	3	3	5	5	4	5	3	3	2	5	3
COHESION	53	47	55	67	80	53	47	56	69	44	45	61	39	57	52		36	46	50	71	39	51		52	48		55	60	56	66	64	64	61	69	61	61	69	50	48	46	57	59
ADABTABILITY	56	56	47	60	66	64	37	55	59	52	45	63	34	52	54		52	61	63	59	42	49		55	47		49	56	51	47	51	55	50	59	52	63	64	50	56	61	52	53

Cohesion mean = 55.49 Sd = 9.92

Adaptability mean = 53.77 Sd = 7.25

Raw Scores: Faces II Ideal